



KING FAHAD HOSPITAL, AL BAHA
Academic Affairs



GENERAL REGISTRATION FORM

Event title:

Event Date:

Event Venue:

CME Hrs Approved:

Please print as you would like to appear in your CME certificate

First Name :

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Middle Name:

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Last Name :

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Title : Prof () Dr () Mr () Ms ()

Profession : _____

Hospital / Institution: _____

Mailing Address : _____

Contact Numbers:

Mobile : _____

Telephone : _____

Fax : _____

E-mail add : _____

I'm here signing that upon attendance of the previously mentioned event I will pay the due registration fees for my category according to the announcement received and this will be equal to: SR

Name :

Signature :