

**GPATI-SIMCUP formular de inregistrare**

Va rugam sa trimiteti formularul prin **EMAIL** la alina.petrica@urgentatm.ro - Contact: Alina Petrica +40744772427

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| **COORDONATORUL ECHIPEI** |
| Nume .......................................................................................... Prenume .......................................................................................................  Adresa ..................................................................................................................................................................................................................................  Oras ........................................................................ Cod postal ....................................................... Tara……………......................................................  Telefon .......................................................................................................................... Fax .................................................................................................  Email (obligatoriu) ..................................................................................................................................................................................................................... |

**Important: Membrii echipei trebuie sa fie inscrisi la conferinta.**

Echipa va fi formata din 4 membrii, un medic ca si team leader/ coordonator, medici si asistenti ca membrii.

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| **MEMBRII ECHIPEI** |
| **NUME**  .......................................................................................... **PRENUME**  .......................................................................................................  Adresa .................................................................................................................................................................................................................................. Oras ........................................................................Cod postal ....................................................... Tara ...................................................... Telefon .......................................................................................................................... Fax ................................................................................................. Email (obligator) .....................................................................................................................................................................................................................  **Asistent Medic** |
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