

## REGISTRATION FORM

Winter Summit in Palliative Medicine: "Heart and Spirit in Palliative Care"

Please send the registration form to: [kizoppal@cm.umk.pl](mailto:kizoppal@cm.umk.pl)

Surname: .....

First name: .....

Street: .....

No. of house/suite: .....

Postcode: .....

City: .....

Country: .....

Phone no.: .....

Email: .....

Employment: .....

Occupation (please select):

- Doctor (please select specialty)
  - Cardiology
  - Palliative medicine
  - Internal diseases
  - Other (please specify) .....
- Nurse
- Psychologist
- Student
- Other (please specify) .....

Age (please tick as appropriate):

- ☐ <35 years old
- ☐ >35 years old

Declaration:

- ☐ I give consent to the processing of my personal data so that I can receive information concerning research and educational activity from the Department of Palliative Care NCU CM.

Legible signature of the participant:

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