

Name _____ Surname _____

Address _____ City code _____ City _____

Phone _____ Mobile _____

Fax _____ e-mail _____

Date of birth _____ Place of birth _____

Profession _____

I want to participate to the following course

I have paid on _____

☐ registration fee of euro 150

☐ total cost of the course of euro _____

The balance of the course must be paid within 10 days before the beginning of the course.

☐ via postal account without expense to the beneficiary N. 34834515 Scuola Elementale di Arte Ostetrica Srl - Via pier capponi 17 - 50132 Firenze.

I send the receipt of the payment attached.

☐ via bank transfer without expense to the beneficiary on the following bank account: N. 0020023720 Scuola Elementale di Arte Ostetrica Srl

Via pier capponi 17 - 50132 Firenze.

UNIPOL BANCA, V.le Matteotti – Firenze

IBAN: IT 62 U 03127 02800 CC0020023720

BIC code: BAECIT2B002

I send the bank statement attached.

Cancellation fee:

Before the registration deadline: restitution of the registration fee with the deduction of euro 30,00 for organization expenses.

After the registration deadline: restitution of the registration fee is not possible.

After the beginning of the course: the total cost of the course must be paid.

I have read and agree with the above conditions.

Signature Date.....