

**The 25th Annual Research Meeting of
the Japanese Orthopaedic Association (JOA)**

Application Form

Please fill out in the blanks and bring this form at the registration desk.

Please check in the blank.

Student Clinical Trainee

Name of Applicant: _____

Affiliation: _____

Address: _____

Tel: _____ Fax: _____

I certify that this applicant is engaged as above.

Director or Supervisor: _____

Signature: _____

Date: _____

Secretariat of JOAR2010

c/o Congress Corporation

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