

CERTIFICATE

To The 129th Annual Meeting of the Japanese Ophthalmological Society

We hereby certify that the below individual is
a Medical Intern / Resident / Graduate Student / Health-Care Professional (Co-Medical)/
Students (Medical)
(Please choose one of the above professionals)

Participant's Name: _____

Participant's Affiliate: _____

Date: _____

Supervisor's / Employer's Signature: _____

Supervisor's / Employer's Print Name: _____

Supervisor's / Employer's Print Title: _____

【Note】

*Please note that only submission of this document does not complete registration.

*Students must provide a photocopy of student ID.

- Please attach a copy of student ID below. -

【Privacy Policy】

Registration Office recognizes the importance of personal information and the importance of our responsibility to protect privacy. Please note that personal information will not be used for purposes other than the congress. Your information will be stored in controlled servers with limited access.

<Inquiries>

129th Annual Meeting of the Japanese Ophthalmological Society Secretariat

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