



# INTERNATIONAL ASSOCIATION FOR STEM CELL TRANSPLANTATION

## Membership Application

**Title:** Prof Dr Mr Ms.

**Name:**

**Gender:** Male Female

**Hospital / Institution:**

**Position:** Specialization:

**Address:**

**P.O Box:** City: Postal Code:

**Country:**

**Tel:** Fax: Mobile:

**E-mail:**

*Fees:*

Physicians: K D 60

Non-Physicians: K D 30

*For more information contact:*

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