Summer Medical Institute Student Workshop
University of Hawaii, John A. Burns School of Medicine
Honolulu, Hawaii USA
August 13-17, 2017

Please complete the following information below and email or fax to Ms. Kori-Jo Kochi at kjkochi@hawaii.edu or +1-808-692-1252, **by July 17, 2017**.

REGISTRANT INFORMATION

Family Name: _____ Given Name: _____

Gender: _____

Medical School/Affiliation: _____ Year of Medical School: ___

E-Mail Address: _____

Mailing Address: _____

City: _____ Prefecture/Province: _____

Postal Code: _____ Country: _____

EMERGENCY CONTACT INFORMATION (Will only be used in case of emergency)

Emergency Contact's Full Name: _____

Relationship (Mother, Father, etc.): _____

Emergency Contact's Phone Number: _____

ROOM SHARING:

☐ Please check here if you are interested in sharing a room with another participant. Please also email your interest to Ms. Kori-Jo Kochi by July 1, 2017

TRAVEL INFORMATION (***You may submit your travel information at a later date.***)

Date of Departure from Home Country: _____ Flight Number: _____

Date of Arrival in Honolulu: _____ Flight Number (if different): _____

Lodging Name: _____

Check-in Date: _____ Check-out Date: _____

Date of Departure from Honolulu: _____ Flight Number: _____