



ENTRY FORM

Second Edition 2010

Use this form for registration by mail and fax.

Return with payment to CAPP KV, Bldg. 9, Off. 8, P.O. Box 502221 Dubai, UAE

CATEGORIES:

- | | |
|---|--|
| <input type="checkbox"/> CONSERVATIVE AESTHETIC BEST CASE | <input type="checkbox"/> ORTHODONTIC BEST CASE |
| <input type="checkbox"/> PROSTHETIC RESTORATION (FIXED AND REMOVABLE) BEST CASE | <input type="checkbox"/> FACIAL RECONSTRUCTION BEST CASE |
| <input type="checkbox"/> IMPLANTOLOGY AND RED-AESTHETIC BEST CASE | <input type="checkbox"/> CHARITY TREATED PATIENT BEST CASE |
| <input type="checkbox"/> STUDENTS BEST CASE | <input type="checkbox"/> STUDENTS BEST RESEARCH |

- * Choose a category or categories you would like to enter. Provide a separate entry for each category.
- * Pre- and post-operative images (jpeg format, not more than 600KB) are required to allow the judges to evaluate the treatment. The images should be chronologically ordered with a date and title (put on a CD).
- * Case report is required (put on a CD).

YOUR DETAILS:

Name:

Specialty..... Clinic:

Country: City: P.O. Box:

Tel.: Fax: Mob:

Email

Dental Technician information (involved in the case):

PAYMENT:

• Bank Transfer

Account Name: CAPP FZ LLC.
KV, Dubai, U.A.E.
Account No: 1011-178649-301
SWIFT Code: EBILAEAD
Bank Name: Emirates Bank
Al Karama Branch, U.A.E.

Please enclose and send by fax or e-mail the proof of payment (bank document)

• Check payment on the name of CAPP

Issue a check on the name of CAPP and send in CAPP office:
CAPP FZ LLC
KV, Bldg. 9, Off. 8
P.O. Box 502221
Dubai, UAE

• Credit Card

Visa Master Card

Card Number: _____

Expiry Date: _____

Card Holder's Name: _____

Address: _____

Date: _____

Signature: _____

3,5% charges for CC payment

No entry fee for Charity treated patient award

Signature: _____

Date: _____

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