**Credit Card Payment Form**

Please fill in below information and return this payment form to the Secretariat by email / mail

**Personal Information**

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|  |
| First Name: |  |
| Surname Name: |  |
| Registration ID:  |  |
| Email: |  |

**Payment Information**

|  |
| --- |
| □ Visa □ MasterCard |
| Cardholder Name : |  |
| Card Number : |  |
| Expiry Date : |  |
| Amount : | HKD |
| Signature : |  |

Email: apben@med.cuhk.edu.hk

 Mail: c/o Faculty and Planning Office
 Faculty of Medicine

 Room G07, Choh-Ming Li Basic Medical Sciences Building

 The Chinese University of Hong Kong

 Shatin, New Territories

 Hong Kong

**Registration Fee**

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| --- | --- |
| \* Students/Staff of The Chinese University of Hong Kong  | Free |
| \* Staff of Prince of Wales Hospital / Hospitals in New Territories East Cluster  |
| \* Staff of Hospital Authority other than New Territories East Cluster or others | HKD 500 |

**\*\*Cancellation and Refund Policy: No refund will be made once the payment is confirmed**