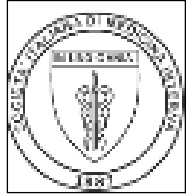


Collaborative Project REPOSI
**PATIENTS REGISTRY FOR POLYPATHOLOGIES AND
POLYTHERAPIES STUDY IN THE DEPARTMENTS OF THE
ITALIAN INTERNAL MEDICINE SOCIETY (SIMI) NETWORK**



REPOSI 2014 SUBSCRIPTION FORM

Please use capital letters

Department already enrolled for REPOSI 2012

NEW Department

Hospital/Company:

Address:

City: ZIP code:

Country.....

Department:

Director

(Prof./Dr.):

Phone: Mobile:

E-mail: Fax:

Investigator(s)

1. Surname and Name (Dr.):

Phone: Mobile:

E-mail: Fax:

2. Surname and Name (Dr.):

Phone: Mobile:

E-mail: Fax:

1 PC available: / yes / no /

Internet access available: / yes / no /

Date:

Director's signature:

Personal data processing (D.Lgs 196/03)

Personal data collected in this form will be processed only for the REPOSI project management and will not be divulged to third parties

Please send the SUBMISSION FORM no later than October 30th 2013

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