

**16<sup>th</sup> Workshop on Resistance to Thyroid Hormone and Action**  
**Ponta Delgada 1-4 September 2026**  
**Registration form**

**Full Name** \_\_\_\_\_

**Title / Designation** \_\_\_\_\_

**Affiliation / Hospital / Organization** \_\_\_\_\_

**Department** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Phone Number (+int. code)** \_\_\_\_\_

**Mailing Address** \_\_\_\_\_  
\_\_\_\_\_

**Passport nº** \_\_\_\_\_ **Issued by (country)** \_\_\_\_\_

**Arrival time** \_\_\_\_\_ **Flight nº** \_\_\_\_\_ **Company** \_\_\_\_\_

**Departure time** \_\_\_\_\_ **Flight** \_\_\_\_\_ **Company** \_\_\_\_\_

**Dietary Constraints:** \_\_\_\_\_

**Special Assistance / Accommodations Required?**  Yes  No

**If yes, please specify:** \_\_\_\_\_

**Room type: Single** \_\_\_\_\_ **Double** \_\_\_\_\_ **Want to share room ?** \_\_\_\_\_

**Accompanying person name** \_\_\_\_\_

**Payment Method (if applicable)**  Credit Card  Bank Transfer  Cash  Other

**Transaction / Reference Number** \_\_\_\_\_

**Consent & Acknowledgment**

I agree to receive updates and notifications related to this medical meeting.  
I consent to photography/video recordings for educational and promotional purposes.  
I confirm that the information provided is accurate and complete.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_