

IMPORTANT REGISTRATION STEPS

- STEP 1** - Complete thoroughly the PDF input/printable Registration Form (followed on the next page) and print it out.
- STEP 2** - Print out the Release Form (see main page for link) and sign it.
- STEP 3** - *Fax Completed **Registration Form** and signed **Release Form** along with a clear copy of the following:
- **Passport**
 - **Medical Insurance Card (front and back sides)**
 - **Biography** (half page by Email to **ciber@fiu.edu**)
- STEP 4** - Please make check payable to **FIU-CIBER** with your social security number for reference and mail it to:
Center for International Business Education & Research (CIBER)
Florida International University
11200 SW 8th S, RB 354B
Miami, FL 33199
- STEP 5** - *Fax your flight information as soon as you purchase ticket to India.
- STEP 6** - *Fax a copy of **Travel Insurance**
Note: Participants are encouraged to purchase the travel insurance which covers emergency medical evacuation and repatriation of remains.
- STEP 7** - *Fax a copy of **visa** as soon as you receive it.
Note: US Citizens require a visa to travel to India.
(see main page for visa information. Visa processing is included in the program fee.

* Please fax all documents to FIU-CIBER at (305) 348-1789

For more information please contact us at (305) 348-1740 or email us at: ciber@fiu.edu

Please see Registration Form on next page.



**Second Annual
Professional Development in International Business (PDIB) Program**

**INDIA
Mumbai and Chennai**

Dec 16-23, 2009

REGISTRATION FORM

First Name: _____ **Last Name:** _____ **Middle Name:** _____
Date of Birth: _____ **Place of Birth:** _____
Citizenship: _____ **Passport number:** _____ **Expiration Date:** _____
Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Home Fax:** _____ **Mobile Phone:** _____
Univ. E-mail: _____ **Secondary E-mail:** _____
University: _____ **Department:** _____ **Title:** _____
Work Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Work Phone: _____ **Work Fax:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

MEDICAL INFORMATION

Physician Name: _____ **Phone No:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Medical Conditions: _____

Medications: _____