



American Healthcare Professionals and Friends for Medicine in Israel

2001 Beacon Street, Suite 210, Boston, MA 02135

Registration

APF's Solidarity Mission in Israel

February 15* - 19, 2026 *Evening

Name (as it appears on your Passport): _____

Mailing Address (including City, State, and Zip code): _____

Phone (including area code): (H) _____ (Cell) _____

E-Mail: _____

Specialty: _____ Date of Birth: _____

Passport Number (required for admission to some sites): _____

Passport Expiration: _____
(Please note that passport must be valid for a minimum of 6 months after entry into Israel)

Please reserve a single room Please reserve a double room

I shall be sharing a room: Circle one of the following: Participant, Spouse Participant or Non-Participant

Accompanying Person's Name: _____

Specialty (if necessary): _____

Passport Number: (required for admission to some sites): _____

Expiration Date: _____ Date of Birth: _____
(Please note that passports must be valid for a minimum of 6 months after entry into Israel)

In case of emergency please contact (include relationship, address and phone):

Credit card information number: _____ Exp.: _____ CVC: _____

Signature: _____ I agree to pay according to card issuer agreement

Please return this form with your \$500 deposit.

Check, Credit Card or Online payments accepted (Make checks payable to APF)

American Physicians Fellowship for Medicine in Israel

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