

# PARTNER FORM



Name: .....

Surname: .....

Address: .....

Address 2: .....

Postal Code: ..... Town: .....

Country: ..... Phone: .....

E-mail: .....

## Amount:

12 €     18 €     30 €  
 60 €     100 €  
 Other: \_\_\_\_\_ €

## Periodicity:

Mensual     Quaterly  
 Semiannual     Annual  
 Unique

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-10 € is the cost of an intervention on a patient with hydrocephalus  
 -20 € is the cost of an intervention in a patient with spina bifida.  
 -30 € is the cost of an intervention a patient with Brain or Spinal Trauma.  
 -35 € is the cost of an intervention a patient with Brain tumor (Craniotomy).

## Method of payment:

Debit my card:     VISA

Other: .....

Card nr.: ..... CSC.: ..... Cad.Date: .....

Banking check, payable to NED Foundation

Direct Debit:    Account (20 digits)

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