מרכז שניידר לרפואת ילדים בישראל

مركز شنايدر لطب الأطفال في اسرائيل

Schneider Children's Medical Center of Israel

Sackler School of Medicine, Tel-Aviv University

CLALIT over 100 years

The Best For Your Family

SCHNEIDER CHILDREN'S MEDICAL CENTER OF ISRAEL
BAR/BATMITZVAH PROGRAM

REGISTRATION FORM

Kindly print, complete in clear block letters, and mail to:
Schneider Children's Medical Center of Israel, Department of External Affairs, 14 Rechov Kaplan, Petach Tikvah 49202, Israel

□ I wish to enroll in the Bar/Batmitzvah Program and help to save children's lives.

Family Name: ______________________________

First Name/s: ______________________________
English Hebrew

Gregorian Date of Birth: ______________________________

Parents First Names: Mother: ______________________________
English Hebrew

Father: ______________________________
English Hebrew

Date of Bar/Batmitzvah: ______________________________
Gregorian Hebrew

Permanent Residence: ______________________________

Country: ______________ Email: ______________________

Telephone: ______________ Cell: ______________________

□ Enclosed please find a check in the amount of ______________ representing my personal gift upon my becoming a Bar/Batmitzvah.

□ I wish to designate my gift towards ______________________________.

Signature: ______________________ Date: ______________

Signature of Parent/Guardian: ______________________ Date: ______________