Registration Form

Please photocopy this form for further registrations.

Course No. ☐ ☐☐ Course Title____________________ Course Date____________________

Membership No.__________ Title (Dr, Mr, Mrs etc)__________ First Name____________________

Surname____________________ Job Title____________________

Company Name____________________

Email Address____________________

Confirmation of booking will be sent by email unless you request here that it is sent by post ☐

Correspondence Address____________________

Post code__________ Country__________ Telephone Number____________________

Special Dietary Requirements____________________

Declaration
I agree to the terms and conditions of booking Signature____________________

Method of Payment
Please note that your place will only be confirmed when payment has been received (please tick as required)

I wish to pay the course fee of £ ☐

☐ I enclose a **cheque** payable to "The Institute of Clinical Research"

☐ **Credit Card** (payment via credit cards are subject to a 3% transaction fee.) ☐ **Debit Card** ☐ **Eurocard**

☐ **American Express**(Please note Amex card payment is subject to an administration charge of between £4 & £10)

Card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

CSC ☐☐☐ Expiry date

Name (as it appears on the card)____________________

Signature of card holder____________________

OR

☐ Please invoice my company using Purchase Order number ☐ Invoices can only be raised when a PO no. is provided

Invoice Address____________________

____________________ Postcode____________________

Return to The Institute of Clinical Research, 10 Cedar Court, Grove Park, White Waltham, Berks, SL6 3LW UK
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