Registration Form

Please photocopy this form for further registrations.

Course No. ☐ ☐☐ Course Title_____ Course Date_____

Membership No._____ Title (Dr, Mx, Mr, Mrs, Miss, Ms)_____ 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** ☐ **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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