

Please complete and sent to [training@icr-global.org](mailto:training@icr-global.org) or fax to +44 01628 501 709

## Registration Form

Please photocopy this form for further registrations

**Course Title:** H7 Clinical Investigations for Medical Devices - Foundation **Course Date:** 27 March 2019

**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

**Address:** .....

**Postcode:** ..... **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 fee of** .....

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

OR

☐ I wish to pay by

☐ VISA

☐ MASTERCARD

☐ DELTA

☐ EUROCARD

Card Number

Start Date

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

Correspondence Address

**Address:** .....

**Postcode:** ..... **Country:** .....