Registration Form

Please complete and sent to training@icr-global.org or fax to +44 01628 501 709

Registration Form

Please photocopy this form for further registrations

Course Title: CAF Clinical Allsorts **Course Date:** 06 September 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 not 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:** .....