

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: EX1 Certificate EXAM **Course Date:** 24 April 2020

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

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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:**