SCM MEDICAL TRAINING

SCM Medical Training LTD
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Registration Form

Please complete in CAPITALS and return this page to SCM to reserve a course place. Please keep a copy of our terms and conditions for your reference. You can Email, Fax or post.

Course Name:

Course Date:

First Name : **Surname:**

(PLEASE USE BLOCK CAPITALS, AS NAME HERE IS USED FOR CERTIFICATE. IF IT CANNOT BE READ, THERE WILL BE AN ADMIN FEE TO REPRINT THE CERTIFICATE)

Job title: S/N / Sr / ODP etc.

Department / Name of Ward

Hospital:

Hospital Address:

Hospital Telephone Number: **Extension.** **Pager/ bleep number**

Hospital email address:
(All course confirmation details and handouts are sent via email 1 week before the course takes place. Please ensure that the person who the details have been sent to will not be away 1 week before the course)

Home address: **Home telephone number:**

Mobile No:

Home email address:
(All course confirmation details and handouts are sent via email 1 week before the course takes place. If your hospital server will not allow attachments, please provide an alternative email address)

Course cost:
(Please add VAT 20%)

Your purchase order number (if required by your Hospital)

Person to whom invoice is to be sent:

Dept:

Email Address:

Address:

Cheques made payable to: SCM Medical Training

How did you hear about this course?

Return of a registration form or purchase Order either by post, fax or email, assumes authorisation had been obtained by the delegate to attend the course, and all terms and conditions apply. *Please read the Terms and Conditions of Booking' overleaf.*
Return this form by post, fax or email, or contact us at:
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