Study Day Application Form

Course Name:- _____

Date of Course:- _____

Title:- MRS/MISS/MS/MR

Surname:- _____

First Name(s):- _____

Work Address:- _____

_____

Post Code:- _____ Work Tel No:- _____

Job Title:- _____

E-mail Address:- _____

Qualifications:- _____

Home Address:- _____

Post Code:- _____ Tel No:- _____

Have you any dietary/special needs? YES/NO

If 'Yes', please state:

Where, and for whose attention, should the invoice to cover your course fee be sent?

_____

_____

_____

If your organisation requires a purchase order before payment can be made, please attach it to this form and quote the number here:

Payment by BACS (credit transfer) is the preferred method. The remittance should quote our invoice number and be sent to: The Rotherham NHS Foundation Trust, Financial Services, c/o Woodside, 120 Moorgate Road, Rotherham, S60 2TY

Please return the completed form to:-

Primary Ear Care & Audiology Services
Rotherham Community Health Centre
Greasbrough Road
ROTHERHAM, S60 1RY
(Tel No: 01709 423207/Fax No: 01709 423408)

PLEASE NOTE: THE FULL FEE WILL BE CHARGED IF NOTIFICATION OF CANCELLATION, IN WRITING OR BY E-MAIL, IS NOT RECEIVED AT LEAST 4 WEEKS PRIOR TO THE COURSE DATE