**Course Booking Form**

**To register please complete the details below**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Institution/hospital/company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Course:** **Good Clinical Practice (GCP) in Medical Device Research**

**Please select a payment option below:**

Cash or Cheque

⃰Invoice to employer/institution

⃰ If an invoice is required, please provide details of payee:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grant Code (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PO No. (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return the completed booking form to: Deirdre Hyland ([dhyland@rcsi.ie](mailto:dhyland@rcsi.ie) )