

MRCOG Part 2: Virtual Revision Course

Saturday 7 November – Sunday 6 December 2020

YIO

BOOKING FORM

FEES	Standard Rate
Virtual Revision Course	£345.00

To verify which rate you qualify for, please visit www.rcog.org.uk/events or contact the Events Team on +44 (0) 20 7772 6245. Prices indicated here are inclusive of VAT at 20%. Payment must be sent with this form to confirm your place.

Please tick this box to say you have read and agree to the terms and conditions

PERSONAL DETAILS (BLOCK CAPITALS PLEASE)

College No. (if applicable) _____

Sex: M F

Title (Prof/Mr/Mrs/Ms/Dr etc) _____

Forename(s) _____

Surname _____

Department _____

Hospital _____

Consultant Trainee GP SAS Doctor Medical Student

Retired Fellow/Member Allied Healthcare Professional Other _____

ADDRESS FOR CORRESPONDENCE

House Name/Number and Street _____

Town _____

County _____ Postcode _____

Country (if not UK) _____

Daytime telephone number _____

Email address _____

HOW DID YOU HEAR ABOUT THE CONFERENCE?

Email from RCOG RCOG News Social Media TOG/BJOG

Specialist UK Society mailing Colleague *Other website

*Other external event

*If you ticked "other" please tell us which: _____

Please tick if you do NOT wish your hospital details to appear on the list of participants to be circulated at the conference

Please tick if you would NOT like to be contacted about future RCOG conferences and courses (please note this does NOT exclude you from other RCOG mailings and standard publications)

CARD PAYMENT DETAILS

Visa Eurocard Delta MasterCard Switch Maestro

We regret we cannot accept payment by American Express, Solo or Visa Electron

Card Number: //

Expiry Date: /

Security Code (last 3 digits on the signature strip on the back of the card):

IMPORTANT - If paying by Switch please include your Issue No: or Valid from date: /

PLEASE NOTE THAT WE CANNOT PROCESS YOUR REGISTRATION UNLESS FULL CARD DETAILS (INCLUDING SECURITY CODE AND THE ADDRESS THE CARD IS REGISTERED TO ARE PROVIDED.

IF YOUR REGISTRATION FEE IS TO BE PAID BY YOUR HOSPITAL AND/OR EMPLOYER, WE WILL REQUIRE A REQUEST FROM THEM ON OFFICIAL LETTERHEAD AND PURCHASE ORDER BEFORE WE CAN RESERVE YOU A PLACE. PAYMENT IS REQUIRED BEFORE THE EVENT.

Name and address of cardholder (if different to the details above)

Name of cardholder _____

House Number and Street _____

Postcode _____

Signed _____ Dated _____