

End of Life Care Training Programme

BOOKING FORM

Course Title:	
Course Date:	Fee: £
Personal Information (Please completion) Title (Dr/Mrs/Miss/Ms/Mr/Revd)	lete a new form for each delegate. Photocopies are acceptable)
Surname	First Name
Work Tel:	Home Tel:
Email	
Job Title Organisation Address	Profession (Please select from the list below. If 'Other please specify) Nurse/Doctor/AHP/Social Worker/Spiritual Care/Bereavement/ Education/Senior Mgr/Administrator/ Care Assistant/Other
	Additional Information How did you learn about the course?
Town	GO Course Programme GO Website
County	GO Website GO Course Flyer
Postcode	Recommendation Email Advertising
Coffee and Tea will be supplied	Editorial Other

 By Cheque Please make cheques payable to Great O and course date on the back of the cheque. By Cash 	aks Hospice and put the Course Name
☐ By invoice to Organisation	
Name of Organisation: Address:	Funding Who is funding this course? Yourself Organisation
Please select your preferred method of payment with an 'X	Reciprocal arrangements Otherplease specify
Terms and Conditions BOOKINGS WILL BE CONFIRMED ON RECEIPT OF FULL PAY Cancellation up to 7 days before a course will incur a £ Cancellation 7 days or less prior to a course date will be This form can be photocopied for additional application	10.00 administration fee. e charged at 100% of total fee.
Special needs The Acorn Suite at Great Oaks Hospice has full disabled most special needs. Please contact us on 01594 811910	
Data Protection	

Please return form to Jane Hamilton at Great Oaks Hospice

Your details will be stored at Great Oaks Hospice but not shared with any third parties. If you do not wish to receive further communications from Great Oaks Hospice, please tick

this box. \Box