

Please fax completed form to 0131 275 7512



## Registration Form

*Title:* -----

*First name:* -----

*Surname:* -----

*Position:* -----

*Hospital:* -----

*Address:* -----

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*Email:* -----

*Telephone no:* -----

*Fax no:* -----

I wish to attend\*

I do not wish to attend

*\*Please use the space below to indicate if you have any special dietary requirements or if you require any additional arrangements to be made.*