REGISTRATION FORM

5th European Echocardiography Course on Congenital Heart Disease

UCL Institute of Child Health, 30 Guilford St, London WC1N 1EH

Wednesday 6th to Saturday 9th October 2010

Surname (BLOCK CAPITALS): _____ _____ Prof ☐/Dr ☐/Mr ☐/Ms☐ /Mrs☐

First Name: _____ _____ Male ☐/Female ☐

Job Title: _____ _____

Name of organisation: _____ _____

Full Postal Address: *(Please specify whether home* ☐ *or work* ☐*)* _____ _____

_____ _____

_____ _____

Postcode: _____ _____ Day Tel: _____ _____ Fax: _____ _____

Email: _____ _____

Special dietary/other requirements: _____ _____

For safety reasons, please tick if you use a wheelchair ☐&/or would require personal assistance if the building needed to be evacuated☐

WORKSHOPS: 3 parallel workshops will be held on Saturday afternoon; please indicate your preference (1st, 2nd choice). Places are limited and will be allocated on first come first served basis: you cannot be guaranteed a place on your first choice workshops.

___ **Transoesophageal echocardiography - practising with simulators**

___ **Real-time 3D echocardiography - dataset postprocessing**

N. B.: Basic transthoracic echocardiography - life scanning with patients is NOW FULL

☐ **SOCIAL EVENT:** Friday 8th October – social event and announcement of best score of the test examination **EchoOskar 2010** (Free for delegates but booking is necessary)

PAYMENT

In order to be registered for this event, full payment of fees must be made with your application unless an organisation is paying on your behalf. Bookings for which payment has not been received prior to the event may be cancelled.

PAYMENT BY CREDIT/DEBIT CARD OR CHEQUE

Please note that we do not have a secure email link at present, so if you wish to pay by card, you MUST send your form by post or fax.

Fees:

☐ ***£400 Physicians***

☐ ***£350 EAE Members***

☐ ***£300 Technicians and junior doctors (under 30 years old)***

I enclose the sum of £_____ by **cheque** made payable to **'UCL'** or **'University College London'** *or* I authorise credit / debit card payment (Visa / MasterCard / UK Maestro only)

Credit/Debit Card No:

[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Expires: [ ] [ ] [ ] [ ] Valid from: [ ] [ ] [ ] [ ]

Issue no.: [ ] [ ] [ ] *(Some Maestro cards only)*

We regret that we cannot accept payment by American Express

Name of Cardholder: _____ _____

Cardholder's Signature: _____ _____

Address of Cardholder (if different from above)

_____

_____ Postcode_____

PAYMENT BY INVOICE

We regret that we cannot invoice private individuals or non-UK based organisations. Invoices will not be issued 3 weeks preceding the event.

APPROVAL:

If your organisation wishes to be invoiced, your registration form must be sent in with a purchase order from your trust.

We cannot book you on to the event without this documentation: if it is not attached, your application will not be processed.

It is your own responsibility to ensure that your application is approved by your employer and forwarded to this office.

GENERAL

APPLICANT'S DECLARATION: Data Protection Act 1998: I agree to ICH processing personal data contained on this form or other data which may be obtained from me or other people or organisations whilst I am applying for this event. I agree to the processing of such data for any purpose connected with my attendance at ICH events, or my health and safety whilst on ICH's premises or for any other legitimate purpose. I agree to the terms and conditions above and confirm that payment for this event is enclosed/will be made in full before I attend.

Please tick if you do not agree to your information being used to advise you of forthcoming ICH/GOS events ☐

Date: _____ _____

CANCELLATION: Cancellations must be received in writing on or 2 weeks before the start of the event and will be subject to a 20% administration fee. No refunds will be given for places cancelled within 2 weeks of the start date.

I C H Events, Institute of Child Health, 30 Guilford Street, London WC1N 1EH
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