



ELITE MEDICAL COURSES

Please complete all parts of this application form in BLOCK CAPITALS

Title

Name

Course being booked

Address

Postcode

Email address

Telephone Number

Medical School/Hospital

I understand that if I wish to cancel my place on the course I must give 14 days notice prior to the start of the course.

I have read the terms and conditions on the www.elitemedicalcourses.com website and agree to be bound by them.

Signed

Date

Payment details

Cheque for £ _____ *Please make cheques payable to Elite Medical Courses*

Please debit my credit/debit card for £ _____

Card type

Mastercard Visa Switch Delta

Card Number

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Cardholders Name

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Expiry date ___/___ Start Date ___/___ Switch Issue No _____

Please return completed form to:

Elite Medical Courses
14 Rosebank
Holyport Road
London SW6 6LG

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