

# Training Course Booking Form



Course Title:.....  
 Date:..... Number of Attendees:.....

Please photocopy and complete this form, then return to us to reserve your place

## BOOKER DETAILS PLEASE PRINT YOUR DETAILS IN BLOCK CAPITALS

Dr  Mr  Mrs  Miss  Other

First Name:.....

Surname:.....

Job Title:.....

Department:.....

Trust / Organisation:.....

Address:.....

.....

..... Postcode:.....

Telephone No:.....

Fax No:.....

Email Address:.....

Any special requirements (including dietary, access etc):  
 .....

.....

Signature: ..... Date: .....

## HOW TO BOOK

Please send your fully completed reservation form to:  
**Brookdale Care Training Academy**  
**The Lane, Wyboston**  
**Bedfordshire MK44 3AS** or email to **training@brookdalecare.co.uk**  
 or fax to **01480 215874**

## PAYMENT METHODS

An invoice will be sent on receipt of booking form. We require payment by cheque or BACS, please make cheques payable to: **Brookdale Healthcare**. Payment must be received before the start date. However for ADOS and ADI-R courses, payment must be made a minimum of 6 weeks before the start date.

## CONFIRMATION OF RESERVATIONS

All reservations will be confirmed in writing. Full details, including programme times and venue information, will be forwarded approximately two weeks prior to the conference date. Late reservations will be confirmed by fax or by email.

## RESERVATION & CANCELLATION POLICY

Cancellations must be received in writing at least two weeks prior to the course date to be entitled to a refund, which will be subject to a 20% administration fee (minimum £10). We regret that cancellations received after this date cannot be refunded, and refunds cannot be made for failure to attend the event. However, a substitute delegate will be welcome in your place at any time.

## FURTHER INFORMATION

For further information about all our future events and activities, visit **www.brookdalecare.co.uk/training**, email **training@brookdalecare.co.uk** or call **01480 470047**.

We will use your personal information to process your application. Your data will be securely stored on our database and used to inform you of other training events. If you do not wish to receive information about future events, please tick this box

## DELEGATE NAMES Please continue on a separate sheet if necessary

TITLE	FIRST NAME	LAST NAME	JOB TITLE

## PAYMENT DETAILS

**By Cheque** I enclose a cheque (payable to Brookdale Healthcare) for: £.....

Please send cheque to: **Brookdale Care Head Office, 14 Parkway, Welwyn Garden City, Hertfordshire AL8 6HG**

**BACS** Brookdale Healthcare Sort Code: 60-10-10 Account Number: 85508675

**By Invoice** Please state where invoice is to be sent (if different to above)

Please send an invoice for: £..... to:

Contact Name:.....

Job Title/Department:.....

Organisation/Trust:.....

Address:.....

.....

Purchase Order No:.....

## FOR BROOKDALE USE ONLY:

Delegate No:.....

Date:.....

Payment Ref:.....