

# BOOKING FORM 2008

Please send your completed form and payment to:  
**THE CENTRE FOR CHILD MENTAL HEALTH**  
 2-18 Britannia Row, Islington, London N1 8PA



<b>Name:</b>	<b>Title:</b>
<b>Company Name (if applicable) and Occupation:</b>	
<b>Address:</b>	
	<b>Postcode:</b>
<b>Telephone:</b>	<b>Email:</b>
<b>Signature:</b>	
<b>Where did you hear about us:</b>	

**Conference days cost £145.00**

**Training days cost £110.00**

**Lectures cost £60.00**

Event Date	Delegate Name	Occupation	Cost
<b>Total</b>			

**I have included a cheque for: .....**

**I WISH TO BE INVOICED (INVOICES MUST BE PAID PRIOR TO ATTENDANCE. No tickets or confirmation will be issued until payment of invoices are received in full. It is the responsibility of the delegate to ensure payment is made prior to attendance of the event. NO ADMITTANCE WITHOUT PAYMENT, DISCOUNTS DON'T APPLY TO INVOICING OPTION). INVOICE TO:**

<b>Contact Name:</b>	<b>Title:</b>
<b>Organisation Name and Address:</b>	
	<b>Postcode:</b>