

BOOKING FORM 2010

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



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

Conference days cost £160.00 Training days cost £125.00 Lectures cost £60.00

Event Date	Delegate Name	Occupation	Cost
Total			

<p>SPECIAL REQUIREMENTS</p> <p>Please note that some of our training events include movement and floorwork. If you have any special requirements regarding this please let us know prior to the event.</p> <p>Do you require: hearing loop YES / NO wheelchair access YES / NO</p>
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PAYMENT DETAILS

I have included a cheque for:

I wish to be invoiced invoices must be paid prior to delegate attendance. Invoices issued to third party organisations only. 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 and ticket.**

INVOICE TO (PLEASE WRITE CLEARLY):

Contact Name:	Email address:
Organisation Name and Address:	
	Postcode:

Please photocopy this form for additional bookings