TRAINING REGISTRATION FORM

First Name ……………………..….. Family Name ……………………………….……. Mr. ☐ Ms ☐ Dr.☐

Company/Institution: ………………………………………Title (Responsibility): ……..……………………

Address: …………………………………………………………………………….……………………..…..………..

City: ………………………………… Province: …………………..……….. Postal Code: ……………..…………

Phone No.: ……………………… Fax No.: …………………… Email: …………..……………..…………

Please register me for the following courses:

	Course Title	Location	Date	Price
1.	…………………………………………………………………	…………..…	…………..	………..
2.	…………………………………………………………………	…………..…	…………..	………..
3.	…………………………………………………………………	…………..…	…………..	………..

Sub total (CAD): ………..

Minus the applicable discount, if any (Please specify the % and the amount): ………..

Adjusted Sub total: ………..

Plus GST (5%): ………..

Grand total: ………..

Payment method;

Please find attached a cheque payable to *Quality Medical Regulations services*: ☐

Payment will be sent through PayPal ☐

Payment will be sent through bank transfer ☐

Please note that the full payment is required before the course starting date

To register, please fax this form to QMRS fax number: 613 526 0558 or send it by mail to Quality Medical Regulations Services at 196 Annapolis Circle, Ottawa, Ontario K1V 1Z1

Name: Signature: Date