



Resistance, Treatment Strategies & Pharmacology Workshops APPLICATION FORM, 2008

(Please write clearly)

Initis & Name: Dr /Mr /Mrs /Ms _____

Position: Consultant / SpR / Pharm / Nurse / Community / Other

Unit / Hosp Address: _____

Town: _____

County/City: _____

Post Code: _____

Best Contact Tel No: _____

Email address: _____@_____

Yes, I wish to attend or reserve a place; please tick relevant box

- | | | | |
|--------------------------|-------------------|--|-------------------|
| <input type="checkbox"/> | Wed/Thurs | 20th & 21st February | London |
| <input type="checkbox"/> | Wed/ Thurs | 21st & 22nd May | London |
| <input type="checkbox"/> | Wed/Thurs | 17th & 18th September | Manchester |
| <input type="checkbox"/> | Wed /Thurs | 22nd & 23rd October | Leicester |
| <input type="checkbox"/> | Wed /Thurs | 26th & 27th November | London |

Signed: _____ Date: _____

Please fax-back to the 'ID Education' organiser:

Fax: 0870 4215 611

Acknowledgement will be sent by email