

**Clinical Education Course Booking Form**

*Please print clearly in black ink and BLOCK CAPITALS*

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| **1 Personal details**   |  | | --- | |  |   Title First Name  Surname  Gender  Where did you hear about this course? |

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| **2 Job details**  **Please indicate your job role**  Doctor Nurse Pharmacist Physiotherapist  Occupational If other, please specify  Therapist  **Please specify your area of practice**  Community Acute trust Care home Hospice  Job title Please State Band  Place of work  Length of time in current role  Manager Name  Manager Email |

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| **3 Course**  Title  £  Fee Date  Title  £  Fee Date |

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| **4 Course Pre-requisite**  **NOTE: Delegates MUST have previously completed foundation level and intermediate level communication skills training within the last 3 years. If you do not qualify please email** [**education@stfrancis.org.uk**](mailto:education@stfrancis.org.uk) **for a place on a free of charge communication skills course prior to your preferred course date. We recommend a 3-6 month space following these preliminary courses prior to joining the advanced course. This is to allow consolidation of learning and to maximise your learning from the advanced course.**  **Please state below the date(s) and course title(s) of previous foundation and intermediate level communication skills training attended** |

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| **5 Contact details**  Please note that email will be the main means of contact, so please write clearly and inform the course administrator as soon as possible if it should change  **Work Address**  **Work Phone No**  **Mobile No**  **Email**  **Home Address** |
| **6 Payment Details**  Please note that confirmation of a place will not be possible without completed payment details  I wish to book this course and pay by (please tick and complete as appropriate)  **Bank Transfer** **Invoice**    **Bank Transfer**  **Bank Name**  Lloyds Bank PLC  205 High Street  BERKHAMSTED  Herts HP4 1AP  **Sort Code**  30-90-73  00294353  **Account No**  The Hospice of St Francis  **Account Name**  **Reference**  Please quote **AVCST** and **your name**  **Invoice**  I request an invoice to be sent to  **Name**  **Job title**    **Department**  **Organisation**  **Contact number or**  **Email**  **Address**  **PO Number** |

**Notes**

**Withdrawal/ Deferral by Candidate**

* If a candidate wishes to withdraw from the course and provides up to 8 weeks notice prior to the course start date, the candidate will receive a 50% refund of the course fee.
* If a candidate wishes to withdraw from the course and provides less than 4 weeks notice prior to the course start date, the candidate not be eligible for a refund
* If a candidate is unable to attend due to unforeseen circumstances a £150 deferral fee will apply

**Cancellation by us**

* Occasionally, situations beyond our control mean we have to cancel a course. In the unlikely event that a course is cancelled, delegates will be informed as soon as possible and offered a priority place for the next available course or a full refund of fees if they prefer