St. Patricks Hospital / Marymount Hospice

Course Registration Form

Personal Details:

Full Name: ____ Title (Dr. Mr. Mrs. Ms):_______________

Postal Address (for course correspondence): ____

____

Home Phone No:_______________ Mobile No: _______________ Work No: __________________

Email: ____

Job Title: ____________________________ Organisation: _______________________________

Work Address: ____

What is your profession? Nurse □ Doctor □ Social Worker □ Education □ Administrator □

Care Assistant □ Physiotherapist □ Chaplain□ Other □ Please Specify : ____________________

Professional Identification No: _______________ Year of Registration: ___________ ______

Name of the organization you are registered with ____

Course Details:

Name of Course: ____

Preferred Dates : 1)____________________________________2)________________________________

Course Fee**:** ____

Please send a cheque /postal order made payable to the '**Education Centre, St. Patricks Hospital/ Marymount Hospice**' . Please post this form together with your payment to : **Education Centre, St. Patricks Hospital / Marymount Hospice, Wellington Road., Cork**. Invoices can be arranged on request.

Where did you hear about this course: Qualifax Website □ Word of Mouth □ Hospital Flyer or Email □ St. Patricks Hospital/ Marymount Hospice Website □ Irish Association of Palliative Care Newsletter □ Other □ Please specify: _______________

Tel No: 021 4501201 **Email:** edcentre@st.patricksmarymount.ie **Website:** www.stpatricksmarymount.ie

Signature *:* _________________ **Date*:*** _________________________