



College of Physicians, Singapore: Medicine Review Course 2015
5 – 6 September 2015 | Auditorium, Academia
REGISTRATION FORM

Register by
30 April 2015 to enjoy early
registration fee

Registration Details

(Certificate of attendance will be sent via email after the course)

Designation:	<input type="checkbox"/> Prof <input type="checkbox"/> A/Prof <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Ms		
Family Name:		Given Name:	
Organisation/Institution:			
Mailing Address:			
MCR No. : (local doctor)		Email:	
Contact No.:	Tel.:	Fax:	
Registration Category Please tick (v) as appropriate.	Early Registration Fee (before 30 Apr 15)	Standard Registration Fee	Onsite Registration Fee/Day Registration (For single day session)
Fellow of Academy of Medicine, Singapore	<input type="checkbox"/> SGD150	<input type="checkbox"/> SGD200	<input type="checkbox"/> SGD150
Basic Specialist Trainee / Advanced Specialist Trainee / Resident/ Medical Officer/ House Officer * Circle appropriate	<input type="checkbox"/> SGD200	<input type="checkbox"/> SGD250	<input type="checkbox"/> SGD175
Allied Health / Nursing * Circle appropriate	<input type="checkbox"/> SGD100	<input type="checkbox"/> SGD150	<input type="checkbox"/> SGD100
Non-Fellow Doctor Country: _____	<input type="checkbox"/> SGD225	<input type="checkbox"/> SGD270	<input type="checkbox"/> SGD225
Medical Student Please indicate matriculation number: _____	<input type="checkbox"/> SGD50	<input type="checkbox"/> SGD50	<input type="checkbox"/> SGD50

Please complete and return this form with full payment to:
Medicine Review Course 2015 Secretariat
 College of Physicians, Singapore
 81 Kim Keat Road, #11-00 NKF Centre, Singapore 328836

For further enquiries, please contact the
 Course Secretariat via email at
cps.mrc@ams.edu.sg

Payment by Cheque:

Enclosed cheque number: _____ of SGD _____ made payable to "College of Physicians, Singapore" Payment must be made in Singapore Dollars.

Payment by Credit Card:

Note: Academy of Medicine, Singapore will be collecting the registration fee on behalf of College of Physicians, Singapore

Name of Card Holder: _____ Card Number: _____

Expiry Date: _____ CVS Number (3-digit number on back of credit card): _____

Amount: _____ Signature: _____

For bank transfer, our College bank details are as follows:

Bank Account Name: College of Physicians, Singapore

Bank Name: DBS Bank Ltd

Bank Account: Number: 065-901423-2

SWIFT Code DBSSGSG

Cancellation & Refund Policy: Before 30 April 2015 – 80% refund | After 30 July 2015 – Strictly No refund.

FOR OFFICIAL USE

Received on: _____

Registration number: _____