CLINICAL RESEARCH CENTRE HOSPITAL KUALA LUMPUR
Level 7, Specialist Clinic and Ambulatory Care Centre,
Hospital Kuala Lumpur
50586 off Jalan Pahang
Wilayah Persekutuan Kuala Lumpur
Tel : 03-2615 5555 ext : 1782/178 Fax : 03-2604 1808
gcp.crchkl@gmail.com

REGISTRATION FORM

GOOD CLINICAL PRACTICE WORKSHOP

19 - 21 MARCH 2019 @ PUTRA HOTEL, KUALA LUMPUR

Terms & Conditions :

1. Registration will be on ***First Come First Serve*** basis. To **secure a seat**, KINDLY SUBMIT A COPY OF THESE DOCUMENTS to ***gcp.crchkl@gmail.com*** . Incomplete submission/missing documents **SHALL NOT BE ENTERTAINED NOR PROCESSED**
   - i) Registration Form
   - ii) NRIC/Passport
   - iii) Prove of Payment/ Online Bank Transfer Receipt
2. Fees stated will include **Course Materials, Examination, Refreshments and Lunch**.
3. All payments can be made to:

Bank	:	**CIMB ISLAMIC BANK BERHAD (KG BARU)**
Account Number	:	**86-0005640-3**
Account's Name	:	**PERSATUAN PERUBATAN PASCASISWAZAH HOSPITAL KUALA LUMPUR**
Payment Method	:	**ATM TRANSFER / ONLINE TRANSFER**

4. Please contact the secretariat for more information on hotel accommodation.
5. Any cancellation of participation must be made in writing to the organiser.
6. Any cancellation made **14** days prior to workshop will be entitled for ***Full Refund from Registration Fee.***
7. Any cancellation made **7** days prior to workshop will be entitled for ***50% Refund from Registration Fee.***
8. Clinical Research Centre HKL reserve the right to change the date(s) or speaker(s) for this course if deemed fit without prior notice and further reserve the right to cancel the course without liability other than returning the course fee.
9. **FULL ATTENDANCE IS COMPULSORY**. Certificate will only be rewarded to participants who passed the Multiple-Choice Question (MCQ) Examination on the last day of the programme.

PERSONAL DETAILS

Title : Prof. / Dr / Mr / Mrs / Ms

Printed Name (as per NRIC) : _____

IC/ Passport No. : _____

Designation : _____

Institution : _____

Department : _____

Contact Address : _____

Contact No. : _____

e-Mail : _____

Meal Options

Please select one :

Non-Vegetarian ☐ Vegetarian ☐

Accommodation

Yes ☐ No ☐

If **YES,** please select your preference.

Room Options:

Single Occupant ☐ Twin Sharing ☐

ACKNOWLEDGEMENT

By signing below, I hereby agreed to all the terms and conditions stated in this form.

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(PRINTED NAME) **(DATE)**