



## Registration Form - group

### Contact Details

Organisation : \_\_\_\_\_

Contact person : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

Postcode : \_\_\_\_\_

Telephone : \_\_\_\_\_

Mobile : \_\_\_\_\_

E-mail : \_\_\_\_\_

### Invoice address if different from above

\_\_\_\_\_

\_\_\_\_\_

Postcode : \_\_\_\_\_

### How did you hear about us?

### Course Details

Course Title : \_\_\_\_\_

Course Venue : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

Course Date : \_\_\_\_\_

Number of attendees : \_\_\_\_\_

### Specialist course content you may need us to cover

\_\_\_\_\_

\_\_\_\_\_

### Does your venue have access to an outdoor area where we can run some of our scenarios?

\_\_\_\_\_

### Payment

If booking more than a month in advance a non-refundable 50% deposit will reserve your place. The full payment for your booking is due on the first morning of the course. If booking within one month of the course date the full fee is payable.

The full fee is £ \_\_\_\_\_

I enclose a deposit of £ \_\_\_\_\_ (if one month prior to course date)

I enclose the full fee of £ \_\_\_\_\_ (if within one month of course date)

I enclose a cheque payable to "London First Aid Ltd" for £ \_\_\_\_\_ and agree to pay the balance, if due, on the morning of the course.

Please send an invoice made out to \_\_\_\_\_

Signed: \_\_\_\_\_ Name: \_\_\_\_\_

Please send the completed form to:

Peta @ LFA  
16 Arundel Terrace  
London  
SW13 8DP



## Group attendee details

Name : \_\_\_\_\_

Date of birth : \_\_\_\_\_

Medical conditions, allergies, significant disability information :

\_\_\_\_\_  
\_\_\_\_\_

Emergency contact person : \_\_\_\_\_

Their contact number : \_\_\_\_\_

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Name : \_\_\_\_\_

Date of birth : \_\_\_\_\_

Medical conditions, allergies, significant disability information :

\_\_\_\_\_  
\_\_\_\_\_

Emergency contact person : \_\_\_\_\_

Their contact number : \_\_\_\_\_

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Name : \_\_\_\_\_

Date of birth : \_\_\_\_\_

Medical conditions, allergies, significant disability information :

\_\_\_\_\_  
\_\_\_\_\_

Emergency contact person : \_\_\_\_\_

Their contact number : \_\_\_\_\_

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Name : \_\_\_\_\_

Date of birth : \_\_\_\_\_

Medical conditions, allergies, significant disability information :

\_\_\_\_\_  
\_\_\_\_\_

Emergency contact person : \_\_\_\_\_

Their contact number : \_\_\_\_\_

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