



COURSE – MEDICAL PRACTICE MANAGEMENT COURSE

YOU WILL BE GRANTED ACCESS TO YOUR GOOGLE CLASSROOM ONCE PAYMENT REFLECTS

COURSE FEES: R 2145 per person ex VAT

TOTAL NUMBER OF DELEGATES:

1. DELEGATE DETAILS

First Name and Surname (as to appear on certificate): _____

Company Position: _____

Email (Gmail): _____

Contact number: (w) _____ (c) _____

2. COMPANY / ORGANISATION DETAILS (IF APPLICABLE)

Practice Name: _____

Practice number: _____ Discipline: _____

Postal Address: _____

_____ Postal Code: _____

VAT Reg number: _____

3. DETAILS

Upon completion of the booking form, a quotation will be sent for payment.

An invoice will be issued upon receipt of payment in full.

ALL COMPLETED FORMS ARE TO BE RETURNED TO DALMOR MEDICAL ADMINISTRATION TRAINING INSTITUTE VIA EMAIL: info@dalmor.co.za

Signed by (Name and Surname): _____ on _____

Signature: _____