 

Registration Form

Please complete all sections of this form in **BLOCK CAPITALS.**

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| Title: |  | | | First name: | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Surname: | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| GMC Number *(if applicable)*: | | | | |  | | | | Date of birth: | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Home address: *(including postcode)* | | | | | | | | | | | | | | | | | | |
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| Please provide your contact details including preferred email address were we can send you course information, programmes etc. | | | | | | | | | | | | | | | | | | |
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| Tel (Home). | | |  | | | | | Tel (Work). | | |  | | | | | | | |
|  | | |  | | | | |  | | |  | | | | | | | |
| Mobile. | | |  | | | | | Fax No. | | |  | | | | | | | |
|  | | |  | | | | |  | | |  | | | | | | | |
| Email (Personal). | | |  | | | | | Email (Work). | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Hospital and department: | | | | | | | | | | | | | | | | | | |
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| Current Position: | | |  | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | |
| Grade: | | |  | | | | Specialty: | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Have you attended a Training the Trainers (or similar) course? If “YES” please indicate which course, the date and where you attended. | | | | | | | | | | | | |  |  |  |  |  |  |
| Yes |  |  | No |  |  |
|
| Name of courses  *(eg TTT, MMED etc)* | | | | |  | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | |
| Where was the course held? | | | | |  | | | | | | | | | | | | | |
| Dates of course | | | | |  | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | |
| Please indicate courses you are interested in teaching e.g. BSS, SSS, Vascular etc | | | | | | | | | | | | | | | | | | |
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The information you provide will be held on a College wide database and may be shared with any relevant Specialist Associations located within the Building. It will be used to process your application and stored in accordance with the Data Protection Act 1998.

We would like to keep you informed of events and activities that may be of interest to you. If you **do not** wish for your details to be used for this purpose, please tick here **🞏 (no marketing)**

We may include your place of work and job title on the course webpage, the course programme, and other literature relating to the course for which you are faculty.  This information may also be made available to participants and sponsors.  If you **do not** wish us to share this information, please tick here **🞏 (data protection)**

Please note that it is your responsibility to inform us if there are any restrictions on your GMC membership.

While we make every effort to run courses as advertised, we reserve the right to change the timetable and/or the teaching staff and cancel the courses without liability. We will ensure reasonable notice is provided.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed |  | Date |  |

**Please EMAIL this form to**: bss.greece@gmail.com

University Hospital of Larissa

Mezourlo Larisa

🗏 00306993470454

🖂 bss.greece@gmail.com

Mrs. Evdokia Kokoti