

**TAX INVOICE**

**ABN: 35 655 720 546**

***Medical evaluation of child abuse @* The Royal Children’s Hospital, Melbourne
Wednesday 26th, Thursday 27th and Friday 28th April, 2017**

**Registration and payment form**

**Name:**

**Organisation:**

**Phone number:**

**Email:**

**[ ]** I wish to register my attendance Profession:

**[ ]** I wish to register guests for attendance **[ ]** RACP Advanced Trainee

**Seminar fee:** $880 per person

**Total payable: $ (incl. GST)**

**Cost is GST inclusive and is for all three days. Morning tea, lunch and afternoon tea are provided on all days.**

**Payment method:**

**Please ensure you retain a copy of this registration form for your records. A receipt will be emailed to you upon confirmation of payment.**

[ ]  **Cheque: Please make cheque payable to *The Royal Children’s Hospital***

[ ]  **Credit card:**

**[ ]  Visa** **[ ]  Mastercard** **[ ]  AMEX**

Card number: Expiry:

Verification code: Signature:

Name on card:

**Post, email or fax this registration and payment form to:**

Administrative Officer

VFPMS

Royal Children’s Hospital

PARKVILLE VIC 3052

**Email:** **debbie.fry@rch.org.au** **Fax: (03) 9345 4105**