



**Chapter of Orthopaedic Surgeons**  
**College of Surgeons, Singapore**  
**Principles and Practice of Clinical Research**  
**CREDIT CARD AUTHORISATION & REGISTRATION FORM**

(FOR PAYMENT VIA CREDIT CARD ONLY)

Please fax registration form to (65) 65937880 or email to [bened\\_thong@ams.edu.sg](mailto:bened_thong@ams.edu.sg)

**Registrant's Details**

Name (as in SMC registration): \_\_\_\_\_ MCR No: \_\_\_\_\_

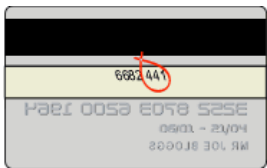
Designation: \_\_\_\_\_ Department: \_\_\_\_\_ Hospital: \_\_\_\_\_

Resident Year (pls circle): 1 / 2 / 3 / 4 / 5 / 6 / NA Email Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_ (O) \_\_\_\_\_ (HP)

This is to certify that I, \_\_\_\_\_ (Credit cardholder's name), cardholder of

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I understand and consent to the use of my credit card without my signature on the charge slip that my signature on this form will serve as the authorised signature.

Thank you.

Yours Sincerely,

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(Cardholder's signature)

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