



Course date:
25 November 2017

Chapter of Orthopaedic Surgeons
COLLEGE OF SURGEONS, SINGAPORE
National Shoulder Arthroscopy Resident Training Workshop

CREDIT CARD AUTHORISATION & REGISTRATION FORM
(FOR PAYMENT VIA CREDIT CARD ONLY)

Please fax registration form to (65) 65937880 or email to joshua_wong@ams.edu.sg

Registrant's Details

Name (as in SMC registration): _____ MCR No: _____

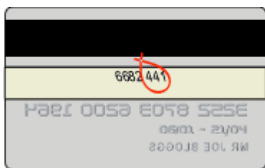
Designation: _____ Department: _____ Hospital: _____

Resident Year (pls circle): 1 / 2 / 3 / 4 / 5 / 6 / NA Contact No. (Mobile) _____

Email: _____

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hereby authorize "**College of Surgeons, Singapore**" to charge a total amount of _____ to the above credit card for payment of registration for the National Shoulder Arthroscopy Resident Training Workshop. Registration fees are non-refundable.

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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