

SCOTTISH CYTOLOGY TRAINING SCHOOL
BOOKING FORM

Name:	Full Time/Part Time
Work Address:	Grade:
Tel:	Fax:
Email:	Trust:
Course Applied For:	
Date of Course:	
Previous Cytology Experience:	
<i>Trainees Only</i>	
Dates of Previous Courses Attended:	
Location:	
<i>Advanced Practitioner Course Only</i>	
Hold Certificate in Cytology:	Yes/No Date:
Fellow of Institute:	Yes/No Date:
Minimum 5 years Cytology Experience:	Yes/No
Training Officer	
Signed:	Lead BMS Date
FOR OFFICE USE ONLY	
Information Pack Sent:	Invoice Sent:
Comments:	