

REGISTRATION FORM FOR IQUR DIAGNOSTICS

Important:

- Please submit this form and await confirmation of registration before sending any samples
- Results will only be provided to the registered person/s

1ST CONTACT DETAILS: (REFERRING DOCTOR OR NURSE) (Patient results will always be posted to this contact unless an alternative name/address is provided)	2ND CONTACT DETAILS:						
Title: Name:	Title: Name:						
ADDRESS:	ADDRESS:						
EMAIL:	EMAIL:						
TELEPHONE:	TELEPHONE:						
FAX:	FAX:						
BILLING ADDRESS:							
DO YOU REQUIRE AN ADDITIONAL METHOD OF RESULT REPORTING (E-MAIL, FAX, PHONE)? Y / N If yes, please state your preferred method : (Tick as appropriate)							
<table border="1" style="border-collapse: collapse;"> <tr> <td style="padding: 2px;">E-MAIL</td> <td style="text-align: center; width: 20px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">FAX</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">PHONE</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		E-MAIL	<input type="checkbox"/>	FAX	<input type="checkbox"/>	PHONE	<input type="checkbox"/>
E-MAIL	<input type="checkbox"/>						
FAX	<input type="checkbox"/>						
PHONE	<input type="checkbox"/>						

Please Email/Fax your completed Registration Form. Alternatively you can send it to:

iQur Ltd.
Room 131/134
Windeyer Building
46 Cleveland Street
London W1T 4JF