Date: 23rd February, 2012 Version: 1.0

APPLICATION FORM: *CLINIC-TOUR*

First name: _____

Surname: _____

Title: _____

Name of Institution/Company: _____

Address:_____

Intended Department of Visit: **Circle as appropriate**

- Imaging
- Radiotherapy
- Nursing
- Administration
- General

Purpose of Visit: _____

_____

_____

_____

Intended Date of visit_____(DD/MM/YYYY)

How much time do you intend to spend? _____hours

Who should be contacted for confirmation of visit?

Name: _____

E-mail address: _____

Telephone number: _____

DECLARATION

I declare that the information provided above is true and complete. Any false or incomplete information provided may serve as ground for delay in visit confirmation and or visit denial.

_____

Applicant's Signature

_____

Date Submitted