

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? Y / N If yes, please state your preferred method : (Tick as appropriate)									
<table border="1" style="float: right; border-collapse: collapse;"> <tr> <td style="padding: 2px;">E-MAIL</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">WEB</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">ACCESS</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">PHONE</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table>		E-MAIL	<input type="checkbox"/>	WEB	<input type="checkbox"/>	ACCESS	<input type="checkbox"/>	PHONE	<input type="checkbox"/>
E-MAIL	<input type="checkbox"/>								
WEB	<input type="checkbox"/>								
ACCESS	<input type="checkbox"/>								
PHONE	<input type="checkbox"/>								

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

iQur Ltd.

**c/o Wiktorja Jonasson
 Wolfson Laboratory
 The Royal Free Hospital
 Pond Street
 London
 NW3 2QG**