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AET Course Booking Form

**All sections of this form must be fully completed and returned by email only to the Training Administrator:** [**sisstraining@solihull.gov.**](mailto:%20%20%20%20%20sisstraining@solihull.gov.)**uk**

**Failure to complete this form in full will result in the form being returned back to you**

**and the course not being booked.**

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| **COURSE TITLE: AET -early -years-good-autism practice** | | | |
| Course Date/s: | No of places required: | Cost per person:  £ | Total Cost  £ |
| **FULL NAME (s) Title of delegate attending the training:** | | | |
| **ROLE OF DELEGATES ATTENDING:** | | | |
| **Can you please confirm candidates are:**  **New to Solihull Yes/No New to Role Yes/No** | | | |
| School or Organisation Name & Postal Address:  Postcode: | | | |
| Tel No:  **Delegate/s Email Address:** | | | |
| Any Access Requirements? | | Any Dietary Requirements? | |
| Signature: | | Date: | |

HOW TO PAY: This section must be completed prior to returning your form payment will be requested immediately after the course date.

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| INTERNAL JOURNAL: SCHOOL NAME: | |
| FULL COST CODE NUMBER to be DEBITED: | |
| AUTHORISED SIGNATURE: | |
| INVOICE: | Name & Address of School/Organisation to be invoiced:  Post Code: |
| Purchase Order Number: |

Date Form Received:

Confirmation Sent:

* We are happy to accept substitute delegates.
* In the event of unforeseen circumstance we reserve the right to cancel or alter parts of the programme.
* CANCELLATION: Should you wish to Cancel a booking we will require 14 days notification prior to the

course date otherwise cancellations or non-attendance will be charged in full.

