



## Aesthetic Medicine Master Class

I wish to attend the 2 Day Aesthetic Medicine Master Class at:  
**HB Health**  
48 Harley Street  
London W1G 9PU

**Time: 09:00 to 18:00**  
**(12 CPD Credits)**

**Dates attending:**

**Sat/Sun 29th - 30th November, 2008**      **Cost £1,000**

**Total £\_\_\_\_\_**

Name \_\_\_\_\_  
Mailing address \_\_\_\_\_  
City/Province \_\_\_\_\_ State/Country \_\_\_\_\_  
Telephone \_\_\_\_\_ Mobile \_\_\_\_\_  
E-mail \_\_\_\_\_

### **PAYMENT INFORMATION**

Cheque payable to Anti-Ageing International Ltd. \_\_\_\_\_  
Credit card Type: \_\_\_VISA \_\_\_MasterCard \_\_\_Switch/Solo \_\_\_\_\_Other  
Name on the Credit Card (print): \_\_\_\_\_  
Credit Card Number \_\_\_\_\_  
Start Date: \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Security Number (three last digits on the back of the card): \_\_\_\_\_

I authorize Anti-Ageing International to charge my credit card. I have provided the amount indicated above. I also agree to pay above total according to my card issues agreement.

Authorized Signature: \_\_\_\_\_ Date \_\_\_\_\_

EMAIL TO: [aesthetic@hbhealth.com](mailto:aesthetic@hbhealth.com)

FAX TO: +44(0) 207 323 1387

Or SEND TO: HB Health  
48 Harley St  
London W1G 9PU UK

