LEWISHAM COLLEGE

# School Statement of Interest

**Please complete this form in CAPITAL LETTERS using black or blue ink**

| School/Local Authority Details | | | |
|---|---|---|---|
| **Organisation / School Name** | | | |
| **Address:** | | **Post Code** | |
| **Name of organisation Main Contact:** | | | |
| **Position:** | | | |
| **Telephone Number:** | | | |
| **Email Address:** | | | |
| **Signature:** | | **Date:** | |

| 14-16 Programme Details | | | | |
|---|---|---|---|---|
| **Name of Student** | **Date of Birth** | **Course Title:** | **Number of Days** | **Year Group** |
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## PLEASE RETURN THIS FORM TO:

School Partnerships Team
Lewisham College
Lewisham Way
London SE4 1UT

schoolpartnerships@Lewisham.ac.uk
020 3757 3353

**SP1**