

ATLS<sup>®</sup> Course, New Delhi

**REGISTRATION FORM - ATLS- INDIA**

***PLEASE FILL IN THIS FORM AND MAIL IT WITH YOUR NON-REFUDABLE PAYMENT OF FEE TO:-***

Advance Trauma Life Support  
Training Programme  
Dr. Ram Manohar Lohia hospital  
New Delhi-110001  
E-mail: [atlsrml@gmail.com](mailto:atlsrml@gmail.com)  
Fax:- 011-23365509  
Tel:- 011-2340 4707 , 23365509  
09868628127, 09811784287

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**1. ATLS Provider Course -**

***PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION:***

**Name:**

**Title:**

**Age:**

**Designation:**

**Specialty:**

**Year of Graduation:**

**Post-Graduate Qualifications:**

**Year of Post-Graduation:**

**Hospital:**

**Address:**

**Zip/Postal Code:**

**Country:**

**Work Phone:**

**FAX:**

**Mobile Phone:**

**E-mail:**

**Date of any ATLS provider course attended along with the registration number:**

**Are you interested in and available for the Instructor course? (Please note that you must successfully complete the Student Course and be identified as having instructor potential to attend the Instructor Course)**

Yes

No

**Please deposit the fees through Bank draft in favour of "Advance Trauma Life Support Training Programme" payable at Delhi. No form will be accepted without full payment.**

**Provide details of Bank Draft No:..... Dated:..... Drawn No:.....**

**Signature**

**For fee refer web. [www.atls.in](http://www.atls.in)**