ATLS® Provider Course, CHAFB Bangalore

# REGISTRATION FORM - ATLS – INDIA

Please fill this form and mail it with your non-refundable payment of fee to:

**Dr. MN Vijai**
**O I/C ATLS Training Cell Command**
**Hospital Air Force**
**Bangalore - 560007**
**Telephone - 9900398708, 9910230411**

**Paste your recent passport size photograph**

**Please give your option for ATLS Provider Course:**

OPTION A 20 - 22 September, 2020

OPTION B

**PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION:**

Name:

Title:

Age:

Designation:

Specialty:

Year of Graduation:

Post Graduate Qualification

Year of Post Graduation:

Working Hospital:

Full Address
For communication:

Zip/Postal Code:

Country:

Work Phone:

Fax:

Mobile:

E-Mail:-

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

Date of any ATLS Instructor 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 "**PMC AF Officers Mess, Trinity Circle**

**A/c No.-0791101027956 Canara Bank, IFSC Code:CNRB0000791.**

No form will be accepted without full payment.

Provide details of Bank Draft No: …… Dated: …… Amount Rs: ……....

Drawn on: ……..

**Signature:**

**COURSE FEE DETAILS:**

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|---|---|
| ATLS Provider Course | |

**§ Submit proof along with the registration form.**