## ATLS® Provider Course, IIEMS Kottayam REGISTRATION FORM

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

George P. Abraham M.D

<b>Course Director, Indian Institute of Emergency Medical Services</b>
1st Floor, Noya Plaza, Kalathippady,
Vadavathoor PO
Kottayam - 686010, Kerala
E-mail:courses@iiems.org
Tel: 0481 3260911 Fax: 0481 2577559
Mob: 9446000485, 9446000472

Paste your recent passport size photograph

Please give your option for ATLS Provider Course:

25-27 Nov 2021

OPTION A

OPTION B

## PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION:

Name:	
Title:	
Age:	
Designation:	
Specialty:	
Year of Graduation:	
Post Graduate Qualificatio	n:
Year of Post Graduation:	
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:

•		ctor course? (Please) note that you must tified as having instructor potential to attend
the Instructor Course).	Yes	No
1		of "Indian Institute of Emergency Medical
Services - INDIA" payable at	Kottayam, Kerala.No fo	rm will be accepted without full payment.

Provide details of Bank Draft No: ...... Dated: ..... Amount Rs. ..... Drawn on: .....

## Signature:

## **COURSE FEE DETAILS:**

	Participants from India & SAARC Countries.	Other Foreign Nationals
ATLS Provider	Rs 25000	USD 600
Course		