ATLS® Provider Course, IIEMS Kottayam

REGISTRATION FORM

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

| George P. A | braham M.D | | | |
|---|--|-----------------|-----------------------|-----|
| Course Dire 1st Floor, No Vadavathoo Kottayam - (E-mail:cour Tel: 0481 32 Mob: 94460 | Paste your recent passport size photograph | | | |
| Please give yo | our option for A | ATLS Provider C | Course: | |
| OPTION A | 08 -10 Augu | ıst, 2024 | | |
| OPTION B | | | | |
| | | | | |
| PLEASE PR | ROVIDE THE | FOLLOWING | G CONTACT INFORMATION | ON: |
| Name: | | | | |
| Title: | | | | |
| Age: | | | | |
| Designation: | | | | |
| Specialty: | | | | |
| Year of Grad | uation: | | | |
| Post Graduat | e Qualification | i: | | |
| Year of Post | Graduation: | | | |
| Hospital: | Γ | | | |
| Full Address | L | | | |
| For Commun | nication | | | |
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| Zip/Postal Code: | | | | |
|---|--|--|--|--|
| Country: | | | | |
| Work Phone: | | | | |
| Fax: | | | | |
| Mobile: | | | | |
| E-Mail:- | | | | |
| Date of any ATLS Provid | ler course attended along with the registration number: | | | |
| | | | | |
| Date of any ATLS Instruc | ctor 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 | | | | |
| 1 | hrough Bank draft in favour of "Indian Institute of Emergency Medical ble at Kottayam, Kerala.No form will be accepted without full payment. | | | |
| Provide details of Bank Draft No: Dated: Amount RsDrawn on: | | | | |
| Signature: | | | | |
| | | | | |
| COURSE FEE DETAIL | LS: | | | |

Other Foreign Nationals

USD 600

Participants from India & SAARC Countries.

Rs 25000

ATLS Provider

Course