ATLS® Provider Course, IIEMS Kottayam

REGISTRATION FORM

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

George P. Abranam M.L	,		
Course Director, Indian Institute of Emergency Medical Services 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	e:	
OPTION A 12-14 Sept	12-14 September, 2024		
OPTION B			
PLEASE PROVIDE TH	E FOLLOWING CO	NTACT INFORMATIO	N:
Name:			
Title:			
Age:			
Designation:			
Specialty:			
Year of Graduation:			
Post Graduate Qualification	n:		
Year of Post Graduation:			
Hospital:			
Full Address			
For Communication			

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 D	Oraft No: Dated: Amount RsDrawn on:		
Signature:			
COURSE FEE DETAIL	LS:		

Other Foreign Nationals

USD 600

Participants from India & SAARC Countries.

Rs 25000

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Course