

ATLS® Provider Course, Manipal Hospital, Bangalore

**REGISTRATION FORM**

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

**Dr. Mabel Vasnaik**  
**Chairperson Accident & Emergency,**  
**Manipal Health Enterprises,**  
**Emergency Department,**  
**Manipal Hospital, HAL Airport Road,**  
**Bangalore 560017**  
**Mob:- +91-9845932624**  
**E-mail: - mabel.vasnaik@manipalhospitals.com**

Paste your recent  
passport size  
photograph

Please give your option for ATLS Provider Course:

OPTION A

OPTION B

**PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION:**

Name:

Title:

Age:

Designation:

Specialty:

Year of Graduation:

Post Graduate Qualification:

Year of Post Graduation:

Hospital:

Full Address  
For communication:

Zip/Postal Code:

Country:	<input type="text"/>
Work Phone:	<input type="text"/>
Fax:	<input type="text"/>
Mobile:	<input type="text"/>
E-Mail:-	<input type="text"/>

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

Date of 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 **Manipal Health Enterprises Private Ltd**, payable in Bangalore. Or it can be paid by direct transfer as per the following details.

**Name:** Manipal Health Enterprises Private Ltd

**Bank Name:** Canara Bank, Manipal Hospital Branch, Airport Road, Bangalore, 56 0017.

**A/C No. – 04851010000630, Account type Current Account NEFT/ IFSC Code: CNRB0010485**

No form will be accepted without full payment.

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

**Signature:**

**COURSE FEE DETAILS:**

ATLS Provider Course	<b>Rs. 20,000/-</b>
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§ **Submit** proof along with the registration form.