## ATLS® Provider Course, New Delhi

## **REGISTRATION FORM - ATLS - INDIA**

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

Advance Trauma Life Training Programme, Trauma Care Centre, Dr. Ram Manohar Lo New Delhi-110001 E-mail: atlsrml@gmai Fax:- 011-23365509 Tel:- 011-2340 4707, 2 09868628127, 0981178	Paste your recent passport size photograph					
Please give your option for	ATLS Provider Course:					
OPTION A 25-27 Septem	25-27 September 2014					
OPTION B						
Name: Title: Age: Designation: Specialty: Year of Graduation:	E FOLLOWING CONTACT INFORMATION	JN:				
Post Graduate Qualification						
Year of Post Graduation:						
Hospital:						
Full Address For communication:						

Zip/Postal Code:				
Country:				
Work Phone:				
Fax:				
Mobile:				
E-Mail:-				
Date of any ATLS Provide	er course attende	d along with the r	egistration numb	er:
Date of any ATLS Instruc	ctor course attende	ed along with the	registration numl	per:
Are you interested in and complete the Student Co-Course)			•	-
	Yes		No	
Please deposit the fees the <b>Programme'</b> payable at				
Provide details of Bank D	raft No:	Dated:	Drawn o	on:
Signature:				

## **COURSE FEE DETAILS:**

	Participants from India	Doctors in Govt.	Resident Doctors	Other Foreign
ATLS	& SAARC Countries.	Services & Armed		Nationals
Provider		forces §		
Course				
	Rs 20000	Rs. 15000 §	Rs. 10000 §	USD 600

<sup>§</sup> Submit proof along with the registration form.