ATLS® Provider Course, New Delhi

REGISTRATION FORM

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

Advance Trauma Life Support

Training Programme, Trauma Care Centre, 6th floor Paste your recent Dr. Ram Manohar Lohia hospital passport size photograph **New Delhi-110001** E-mail: atlsrml@gmail.com Fax:- 011-23365509 Tel:- 011-2340 4707, 23365509 09873674895, 09811784287. Please give your option for ATLS Provider Course: OPTION A Nov 21-23, 2024 **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:	
Work Phone:	
Fax:	
Mobile:	
E-Mail:-	
Date of any ATLS Provid	er course attended along with the registration number:
Date of any ATLS Instruc	etor course attended along with the registration number:
•	available for the Instructor course? (Please note that you must successfully urse and be identified as having instructor potential to attend the Instructor
	Yes No
Please deposit the fees the	rough Bank draft in favor of "Advance Trauma Life Support Training
Programme for Doctors	" payable at New Delhi. No form will be accepted without full payment.
Provide details of Bank D	raft No: Dated: Drawn on:
Signature:	

COURSE FEE DETAILS:

Participants from India	Doctors in Govt.	Resident Doctors	Other Foreign
& SAARC Countries.	Services & Armed		Nationals
	forces §		
Da 21500	Da 16500 8	Da 11500 8	USD 600
KS 21300	Ks. 10300 g	KS. 11300 g	USD 600
	1 *	& SAARC Countries. Services & Armed forces §	& SAARC Countries. Services & Armed forces §

[§] Submit proof along with the registration form.

Account Details

Account Name: Advance Trauma Life Support Training Programme for Doctors

Account No.: 26020100011146 MICR CODE: 110012061

IFSC: BARBORAMDEL (Fifth character is a zero)