ATLS® Provider Course, New Delhi

REGISTRATION FORM - ATLS – INDIA

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

Symbiosis Institute of Health Sciences
Senapati Bapat Road,
Pune – 411004
Phone no. 020-25658012/13/14/15
Fax: 020 - 25658015
Email- pgdems@sihspune.org

Paste your recent passport size photograph

Please give your option for ATLS Provider Course:

OPTION A 11 - 13 Apri 2013

OPTION B

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PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION:

Name:	
Title:	
Age:	
Designation:	
Specialty:	
Year of Graduation:	
Post Graduate Qualification	
Year of Post Graduation:	
Working Hospital:	
Full Address For communication:	

Zip/Postal Code:	
Country:	
Work Phone:	
Fax:	
Mobile:	
E-Mail:-	

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

Date of any 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 **"Symbiosis Institute of Health Sciences" payable at Pune**. No form will be accepted without full payment. Provide details of Bank Draft No…..…… Dated: …… Drawn No ……

Signature:

COURSE FEE DETAILS:

	Participants from India & SAARC Countries.	Other Foreign Nationals
ATLS Provider Course	**Rs 20000**	**USD 600**