# ATLS® Provider Course, Bangalore
# REGISTRATION FORM

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

**Dr. Aruna C Ramesh**
**Department of Emergency Medicine,**
**Ramaiah Memorial Hospital**
**New Bel Road, Bangalore-560054**
**Mob:- +91-9740087555**
**E-mail: - atlsramaiahbangalore@gmail.com**

**Paste your recent passport size photograph**

**Please give your option for ATLS Provider Course:**

OPTION A 10-12 December, 2020

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 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 favor of "**M S Ramaiah Memorial Hospital" A/c No. - 141200300000266 Bank Vijaya Bank, Branch - MSRIT Yeshwanthapur, RTGS / NEFT Code: VIJB0001412, Account Type:- Current A/C, Bank Branch:- MSRIT, Yeshwanthpur. PAN No.: AAATG1779Q**

No form will be accepted without full payment.
Provide details of Bank Draft No:……. Dated:…… Drawn on:……

**Signature:**

**COURSE FEE DETAILS:**

| | |
|---|---|
| ATLS Provider Course | **Rs. 25000/-** |

**§ Submit** proof along with the registration form.