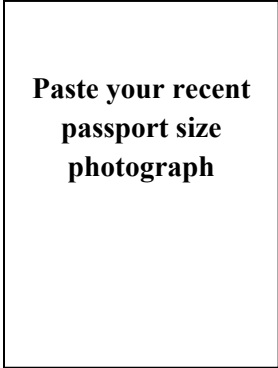


**ATLS® Provider Course, Bangalore**  
**REGISTRATION FORM**

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**



**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:

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, Yeshwanthapur. 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	<b>Rs. 25000/-</b>
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§ **Submit** proof along with the registration form.