CHICAGO COMMITTEE ON TRAUMA
Of THE
AMERICAN COLLEGE OF SURGEONS
ATLS® **PROVIDER** COURSE REGISTRATION FORM

NAME:_____ _MD/DO/DDS/DMD/PA-C/NP
Last First Middle Initial (Circle one)

_____
Street (circle: Home or Office)

_____
City State Zip Country

DAYTIME TELEPHONE :_____CELL TELEPHONE:_____

E-MAIL:_____

HOSPITAL AFFILIATION:_____

_____
City State

U.S. MD/DO/DDS/DMD LICENSE NUMBER: _____State:_____
(If you do not have a US license, please provide documentation of your license to practice medicine)

DATE & SITE OF ANY PREVIOUS ATLS COURSE_____
If taken ATLS in the past, please be sure to complete the above requested information.

PLEASE CHECK APPROPRIATE SPECIALITY:
_____Emergency Medicine _____Primary Care _____Surgery (Sub-specialty_____
_____Internal Medicine _____Pediatrics

PLEASE INDICATE YOUR STATUS:
_____Attending_____Resident _____Year_____Other _____

DATES OF DESIRED COURSES:

1ST Choice: _____2nd Choice: _____3rd Choice: _____

We are able to offer the following payment options:

Paying by check	$950.00	Paid by check
Paying with a credit card:	$975.00	Paid by credit card

(we do not take American Express)

Please make your check payable to: ATLS® Course and include with your completed Registration Form.
If you would like to use a credit card, please complete the below requested information.

Type:_____Acct.# _____

Security Code: _____ _____ _____ Expiration Date: _____

Name on Credit Card:_____

Address on Credit card: _____

E-mail: _____

Phone Number:_____

Mail Completed Registration Materials To: **Judith E. Brasic, RN**
ATLS Coordinator
723 Bethel Avenue
Bolingbrook, IL 60490

ATLS® Courses are filled on a first come, first served basis. Please identify (3) three choices from the enclosed list of course dates.
Upon receipt of your completed form and registration fee, we will notify you of course availability

Refund Policy:
1. 80% up to one month before course date
2. No refund thereafter
3. Fees will not be refunded for failure to attend

CHICAGO COMMITTEE ON TRAUMA
Of THE
AMERICAN COLLEGE OF SURGEONS
ATLS® **REFRESHER** COURSE REGISTRATION FORM

NAME:_____ MD/DO/DDS/DMD/PA/NP
Last First Middle Initial (Circle one)

_____
Street (circle: Home or Office)

_____
City State Zip Country

DAYTIME TELEPHONE:_____CELL TELEPHONE:_____

E-MAIL:_____

HOSPITAL AFFILIATION:_____

_____
City State
DATE & SITE OF LAST ATLS COURSE_____

Please enclose a copy of your ATLS Card or documentation letter. Your Registration form cannot be processed without this documentation of your current ATLS status

U.S. MD/DO/DDS/DMD LICENSE NUMBER: _____ _____State:_____
(If you do not have a US license, please provide documentation of your license to practice medicine)

PLEASE CHECK APPROPRIATE SPECIALITY:
_____Emergency Medicine_____Family Medicine_____Surgery (Sub-specialty_____
_____Internal Medicine _____Pediatrics

PLEASE INDICATE YOUR STATUS:
_____Attending_____Resident _____Year_____Other _____

DATES OF DESIRED COURSES:
1ST Choice: _____2nd Choice: _____3rd Choice: _____

COURSE FEES: (We do not Take American Express)

Paid by check:	$650.00 Paid by check
Paid with a credit card:	$675.00 Paid by credit card

Please make your check payable to: **ATLS® Course**
Please be sure to include documentation of your current ATLS provider status.
If you would like to use a credit card, please complete the below requested information.

Type:_____Acct.# _____

Security Code:_____ Expiration Date: _____

Name on Credit Card:_____

Address on Credit card: _____E-Mail:_____

Phone Number:_____

Mail Completed Registration Materials To:

Judith Brasic, RN
ATLS Coordinator
723 Bethel Avenue
Bolingbrook, IL 60490

ATLS® Courses are filled on a first come, first served basis. Please identify (3) three choices from the enclosed list of course dates.
Upon receipt of your completed form and registration fee, we will notify you of course availability
Refund Policy: 1. 80% up to one month before course date 2. No refund thereafter 3. Fees will not be refunded for failure to attend