



Australian
Resuscitation
Council



INSTRUCTOR COURSE

REGISTRATION FORM

<p><u>INSTRUCTOR COURSE DETAILS</u></p> <p>Date:</p> <p><input type="checkbox"/> 2/3 June 2010</p> <p><input type="checkbox"/> 19/20 October 2010</p> <p>Time: 08:00 - 18:00 Day 1 & 2</p> <p>Location: Royal Perth Hospital Centre for Education WASON Building Wellington Street PERTH WA 6000</p> <p><u>REGISTRATION TYPE</u></p> <p><input type="checkbox"/> Instructor Candidate \$450.00 inc GST</p> <p><u>METHOD OF PAYMENT</u></p> <p><input type="checkbox"/> Enclosed is a cheque for \$ _____ made payable in Australian Dollars to the "Australian Resuscitation Council".</p> <p>Or</p> <p>Please debit my: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Diners</p> <p>For the amount of \$ _____ (incl. GST)</p> <p>Card No. _____</p> <p>Expiry Date: ____/____</p> <p>Cardholder Name: _____</p> <p>Signature: _____</p>	<p><u>CONTACT DETAILS</u></p> <p>Mr/Ms/Dr/Prof: _____</p> <p>First Name: _____</p> <p>Surname: _____</p> <p>Address: _____ _____ _____</p> <p>Postcode: _____</p> <p>Email: _____ <i>(email is preferred method of contact)</i></p> <p>Telephone 1: _____</p> <p>Telephone 2: _____</p> <p>Nurse <input type="checkbox"/> Registrar <input type="checkbox"/> Consultant <input type="checkbox"/> Nurse <input type="checkbox"/> Paramedic <input type="checkbox"/> Other _____</p> <p>Current Hospital: _____</p> <p>Current Department: _____</p> <p>Current Position: _____</p> <p><u>DIETARY REQUIREMENTS</u></p> <p>Please indicate if you have any special dietary requirements that our caterers need to be aware of: _____ _____</p> <p>Course Centre & Date of ALS course when nominated as IP</p> <p>Course Centre _____</p> <p>Date: _____</p> <p>Courses/Dates undertaken as observer since: _____ _____</p>
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LODGING YOUR REGISTRATION

In case of cancellations within 4 weeks of the course, the full course fee will be charged. The full course fee is transferable to a future instructor course or substitute course participant.

Declaration

The information I have supplied in this application form is correct and I understand and agree to the conditions above.

Signed:

Date:

Please return your completed registration form to:

Mrs Carol Carey
Executive Officer
Australian Resuscitation Council
C/- Royal Australasian College of Surgeons
College of Surgeons' Gardens
250-290 Spring Street
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