



INSTRUCTOR COURSE

REGISTRATION FORM

INSTRUCTOR COURSE DETAILS

Date:

10/11 May 2012

Time: 08:00 - 18:00 Day 1 & 2

Location: **NCCTRC- 8th Floor
Royal Darwin Hospital
Rocklands Drive
TIWI NT 0810**

REGISTRATION TYPE

Instructor Candidate **\$450.00 inc GST**

METHOD OF PAYMENT

Enclosed is a cheque for \$ _____ made payable in Australian Dollars to the "**Australian Resuscitation Council**".

Or

Please debit my: Visa MasterCard AMEX
 Diners

For the amount of \$ _____ (incl. GST)

Card No. _____

Expiry Date: ____/____

Cardholder Name: _____

Signature: _____

CONTACT DETAILS

Mr/Ms/Dr/Prof: _____

First Name: _____

Surname: _____

Address: _____

Postcode: _____

Email: _____

(email is preferred method of contact)

Telephone 1: _____

Telephone 2: _____

Nurse Registrar Consultant Nurse

Paramedic Other _____

Current Hospital: _____

Current Department: _____

Current Position: _____

DIETARY REQUIREMENTS

Please indicate if you have any special dietary requirements that our caterers need to be aware of: _____

Course Centre & Date of ALS Provider course when nominated as IP

Course Centre _____

Date: _____

Courses/Dates undertaken as observer since:

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
EAST MELBOURNE VIC 3002
Tel: (03) 9249 1214
Fax: (03) 9249 1216
Email: ARC@surgeons.org
Website: www.resus.org.au

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