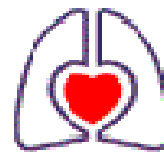




**Egyptian Resuscitation Council**



**E**uropean  
**R**esuscitation  
**C**ouncil

## REGISTRATION FORM

### European Paediatric Life Support Course

LAST NAME ..... MIDDLE NAME ..... FIRST NAME .....

TITLE ..... BIRTH DATE ..... GENDER .....

E-MAIL ADDRESS .....

**Have you previously applied to or attended this council? If yes, what year?**

YES .....  No

CELL PHONE NO. : .....

HOME TEL NO. : .....

CONTACT ADDRESS : .....

CURRENT HOSPITAL : .....

WORK TEL NO : .....

AREA OF SPECIALTY : .....

I Understand that it will be responsibility to keep the Egyptian Resuscitation Council Informed of any change of my Information

Sign .....

Date .....

For more information contact us :

TelFax : 03-5826956      Mobile : 01222406481

Website : [egrc.org.eg](http://egrc.org.eg)