PHOTO

9th Ostomy Care Management Course

STUDENT REGISTRATION FORM

Initials Dr/RN/other	Name as to appear on Certificate.			
e-mail address:		Sex	Male Female	
Country code	+		Mobile:	
ID/ passport #:			DOB: ...00/month/year…	
Professional. board #:				
Facility of Practice:		Country of Origin		
Professional designation:				
Tertiary Qualifications:				
Qualification	Institution attained:		Year	
Degree:				
Wound Care Experience:				

Signature_____Date_____

Course fees to be transferred electronically into the following account:
ACCOUNT TITLE: STARS MEDICAL ASSISTANCE CENTER
ACC #:**019120017376** IBAN: AE830330000019120017376
Bank Name: Mashreq Bank Branch: Zayed 2nd Branch
City/State: Abu Dhabi Country: United Arab Emirates
Swift Code: BOMLAEAD

Send copy of your last qualification, registration form with your professional Board and current license of practice to **Ms. Shyja Koshy, e-mail Admin at:**info@iiwcg.com
info@smacuae.com

Once you receive the confirmation and approval of your registration then send the Money to the given account and send the receipt by e mail as scanned copy.

I accept that no access to the course will be granted without payment of a registration fee