

Continuing Professional Education in Wound Healing Science 2026-2027

STUDENT REGISTRATION FORM Abu Dhabi 14th Group

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: BOMLAHAD

Send copy of your last qualification, registration form with your professional Board and current license of practice to admin at: iiwcc.ae2@gmail.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