

**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**