Symbiosis Center for Health Skills (SCHS)

Department of Symbiosis International (Deemed University)

ITLS Student Data Form

ITLS Course information will be completed online. The following information must be provided by each student seeking an ITLS certification. All items are mandatory to receive a card and certificate upon successful completion of the course.

First Name:_____

Last Name:_____

Educational Qualification: _____

Credentials (Circle all that apply)**:** MD DO RN EMT-P EMT-B EMT-I Other:_____

Home Address:_____

_____

City: _____ **State/Province:** _____ **Zip / Postal Code:** _____

E-mail Address: _____**Phone Number:** _____

Skill Level (Circle ONE only)**:** Advanced Basic

State License Number*: _____ **State of Licensure:** _____

**NOTE: If you do not have a state license number, please enter your birthdate in the following format: MM/DD/YYYY*

License Type*(Circle ONE only):CFR EMT-1 EMT-2 EMT-B EMT-CC EMT-D EMT-Int EMT-P Other

**NOTE: Please choose the designation that most closely matches your license type. Advanced care providers whose license type does not appear above (such as RNs and physicians) should select "Other."*

State License Expiration Date (MM/DD/YYYY): _____

NREMT Certification Number: (if applicable: _____

NREMT Expiration Date: (if applicable):_____

Date of workshop want to attend:

Signature of Applicant Signature of Organizer