# International Request for ATLS® Program

This form is designed to facilitate the application and review process for introducing the ATLS® Program into your country via an established surgical organization or ACS Chapter. Please provide the information requested and return it to the address provided at the bottom of the form. Please keep this form intact until the review and approval process is completed. Thank you.

Date of Request: _____/_____/_____
Name of individual completing application: ______________________________
Title: ______________________________
Relation to organization: ______________________________

Name of Requesting Organization/ACS Chapter: ______________________________
President of Organization/ACS Chapter: ______________________________
Address: ______________________________
______________________________
______________________________
______________________________
______________________________
email: ______________________________
Telephone Number: _____-_____-_______________ FAX Number: _____-_____-_______________

***Please attach the following information about your organization to this form:***

- Background information about the surgical organization, including qualifications for membership, mission statement, most recent annual report, and number of members.
- Length of time surgical organization or ACS Chapter has been in existence ________________________
- Support letter from organization's president ❒ Attached /enclosed
- Is this the principal surgical organization in your country? ❒ Yes ❒ No (Please list others)
- Has an ATLS® Working group been appointed? ❒ Yes (Please list by name, location, position and organization affiliation) ❒ No
- Are there any other entities/agencies within your country that would be financially or organizationally supporting the program in your country? ❒ Yes (Please list by name and location) ❒ No

***Please attach to this form, your response to these queries:***

- Please briefly describe the reason for this request.
- Please provide your objectives for the program and projected training plans.
- Where do you propose the inaugural ATLS® Program will be conducted?
- What is the doctor population in your country that potentially would be interested in participating in the program?
- How is the doctor population distributed in your country, ie, rural vs urban?
- What is the incidence of multisystem trauma in your country?
- Please provide a brief overview of how the injured patient currently is managed in your country.

***Please forward this form and the requested information to:***
John B. Kortbeek, MD, FRCSC, FACS
International ATLS® Course Director
c/o Will Chapleau
ACS ATLS® Program
633 North Saint Clair St.
Chicago, IL 60611-3211 (312) 202-5160 FAX: (312) 202-5005

***Approved/Deferred*** (For ACS Use Only)

| | | | |
|---|---|---|---|
| Request approved by subcommittee? | ❒ Yes | ❒ No | Date:____/_____/______ |
| Request approved by Executive Committee? | ❒ Yes | ❒ No | Date: ____/____/______ |
| Letter of Approval/Deferment sent to requesting entity? | ❒ Yes | ❒ No | Date: ____/____/______ |
| If request deferred, letter of explanation provided? | ❒ Yes | ❒ No | Date: ____/____/______ |

Amended 1/13/94, 1/19/94, 1/22/94, 1/23/98, 4/16/01, 5/22/2003, 3/2009