



## COURSE REGISTRATION FORM

**EACTS Executive Secretariat**  
3 Park Street, Windsor, Berks SL4 1 LU, UK  
Tel: + 44 (0)1753 832166, Fax: +44 (0)1753 620 407  
E-mail: [info@eacts.co.uk](mailto:info@eacts.co.uk)  
Website: [www.eacts.org](http://www.eacts.org)

### Important Notes:

Forms must be legible  
Complete forms in CAPITAL  
LETTERS & Black Ink

Family Name \_\_\_\_\_

First Name \_\_\_\_\_ Title: Dr/Mr./Ms \_\_\_\_\_

Date of Birth \_\_\_\_\_ Received Medical Degree in Year \_\_\_\_\_

Professional Position \_\_\_\_\_

Start date of training in cardiac and/or thoracic surgery:

\_\_\_\_\_ Year \_\_\_\_\_ Month

Department \_\_\_\_\_

Hospital \_\_\_\_\_

Address \_\_\_\_\_

City and Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Email address is required

Email \_\_\_\_\_

Telephone No + (Country Code) \_\_\_\_\_

Fax No\_+ (Country Code) \_\_\_\_\_

Please ensure that all  
necessary documents are  
attached to this application.

- Brief CV
- Recent Photo
- Copy of National  
Medical Diploma
- List of Publications

Optional:

- Summary of operational  
experience

### Certification From Chief of Department

I (Head of Department) \_\_\_\_\_

Family Name \_\_\_\_\_

First Name \_\_\_\_\_ Title: Dr/Mr/Ms \_\_\_\_\_

Certify that the Applicant works as a trainee in my department

At (Hospital/Institution) \_\_\_\_\_

Email \_\_\_\_\_

Telephone No + (Country Code) \_\_\_\_\_

Fax No\_+ (Country Code) \_\_\_\_\_

Head of Department Signature \_\_\_\_\_

Date



An administration charge of €25 is included in the Course Fee. There will be no refund of this administration charge if you do not attend a course. Registrations without payment will not be processed.

CARDIAC			
Dates	Level	Latest Date for Receipt of Applications	Tick which course you wish to attend
6 – 11 March 2006	B	31 January 06	
15 – 20 May 2006	A	17 March 06	
13 – 18 November 2006	C	22 September 06	
THORACIC			
3 – 8 April 2006	A	6 February 06	
12 – 17 June 2006	B	14 April 06	
16 – 21 October 2006	C	18 August 06	

**Course Fee: €900 \* includes non-refundable Administration Fee of €25**

**Payment Method**

Credit Card (Visa / MasterCard / American Express accepted)

**Payment**

Credit Card Number \_\_\_\_\_

Expiry Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cardholder's Name \_\_\_\_\_

Bank Transfer with no charges to EACTS Trading Company Ltd, mentioning applicant name and "ESCTS"

Account Name: **EACTS Trading Company Ltd**

Account Number: **EACTRA-EUR**

Bank Code: **16-00-16**

Name of Bank: Royal Bank of Scotland

Signed.....Date.....

**CHEQUES ARE NOT ACCEPTED**

**Sponsor Organisation (If different from above)**

Hospital/Company. \_\_\_\_\_

Address \_\_\_\_\_

City & Post/ZIP Code \_\_\_\_\_ Country. \_\_\_\_\_

Contact Person \_\_\_\_\_

Email (Required) \_\_\_\_\_

Telephone No + (Country Code) \_\_\_\_\_

Fax No\_+ (Country Code) \_\_\_\_\_

**Fax to**

+44 1753 620407

or

**Mail to**

EACTS Executive Secretariat:

3 Park Street

Windsor

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