



**APPLICATION
for
ITLS Chapter**

Date of Application: ___/___/___
mm/dd/yy

(1) What organization is requesting to become an ITLS Chapter?

Name _____

Address _____

Country _____ ZIP/Postal Code _____

Telephone _____ Fax _____

Website _____

Is this a governmental agency? **YES** **NO**

Is this a not-for-profit organization? **YES** **NO**

If the organization is neither not-for-profit nor governmental, please describe its corporate structure: _____

Please describe the activities of this organization relevant to EMS education:

A letter of support from the sponsoring organization with signature of responsible individual must accompany the application.

(2) Please describe the geographic area for which the ITLS chapter is requested.

NB: ITLS may establish more than one chapter or training centre in any geographic area.

(3) What is the purpose of the organization?

(4) Please provide information on any ITLS courses that have been conducted in your area:

Date Course Location Course Coordinator # of Students

Please use additional sheets if necessary.

(5) Who will be the Chapter Coordinator?

Name _____

Credentials _____

Title _____

Address (if different from above)

Phone _____ Fax _____

Email _____

Is this the primary contact for ITLS? **YES** **NO**

Is he/she a current ITLS instructor? **YES** **NO**

Is he/she a current ITLS provider? **YES** **NO**

Please describe his/her EMS and administrative experience:

Please attach a current CV and a copy of ITLS instructor card if applicable.

(6) Who will be the Chapter Medical Director?

Name _____

Credentials _____

Title _____

Address (if different from above)

Phone _____ Fax _____

Email _____

Is he/she a current ITLS instructor? **YES** **NO**

Is he/she a current ITLS provider? **YES** **NO**

Please describe his/her EMS and administrative experience:

Please attach a current CV and a copy of ITLS instructor card.

(7) Please list the names of any current ITLS *instructors* in your area and indicate the ITLS chapter where they received their certification. Please attach copies of their ITLS cards.

Name

Chapter Certified

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

Please use additional sheets if necessary.

(8) Has an ITLS Advisory Committee been formed? YES NO

If YES, please describe its membership:

(9) What arrangements will be made for Chapter administrative support?

(10) What groups will be involved in developing ITLS policy?

(11) What ITLS courses do you intend to run?

___ ITLS Provider – Basic ___ ITLS Provider – Advanced ___ ITLS Provider – Combined
___ ITLS High Threat ___ ITLS Duty to Respond ___ eTrauma
___ ITLS Pediatric ___ ITLS Access ___ eTrauma Completer

I hereby agree that as the designated ITLS Chapter Coordinator I will undertake the duties of the position with diligence and abide by the ITLS Chapter Policy and Procedure manual and the ITLS rules and guidelines.

Printed Name

Date

Signature

I hereby agree that as the designated ITLS Chapter Medical Director I will undertake the duties of the position with diligence and abide by the ITLS Chapter Policy and Procedure manual and the ITLS rules and guidelines.

Printed Name

Date

Signature

Please submit an electronic copy of your application and proposed ITLS Policy and Procedure Manual to:

ITLS
4950 W Royal Ln
Irving, TX, 75063
8888.495.ITLS
630.495.6442

www.itrauma.org