ATLS™
ADVANCED TRAUMA LIFE SUPPORT

The Committee on Trauma

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

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 American College of Surgeons (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		TELEPHONE
E-MAIL		FAX

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

- Background information about the surgical organization, including qualifications for membership, membership 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**
- 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**
- Are you aware of any previous or simultaneous requests?
  ◯ **Yes** ◯ **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 (for example, rural versus urban)?
◯ Please provide a brief overview of how the injured patient is currently managed in your country.

The Region Chief has been made aware of this application for promulgation?
◯ **Yes** ◯ **No** **Date** _____

Please forward this form and the requested information to:

ATLS Program
633 N. Saint Clair St.
Chicago, IL 60611-3211

Phone: 312-202-5160 / Fax: 503-202-5013 /
E-mail: traumaed@facs.org

Approved/deferred
(For ACS use only)

Amended 1/13/94, 1/19/94, 1/22/94, 1/23/98, 4/16/01, 5/22/2003, 3/2009, 12/2015

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 approved, letter of explanation provided?
◯ **Yes** ◯ **No** **Date** _____