

ILLINOIS COLLEGE OF EMERGENCY PHYSICIANS ITLS ILLINOIS POST COURSE CHECKLIST

**This checklist must be sent with course materials
Must be received no more than two weeks after course**

ICEP
Attn: ITLS Illinois Chapter Coordinator
1 S 280 Summit Avenue, Court B-2
Oakbrook Terrace, IL 60181
630-495-6404 FAX
info@itraumailinois.org

| Date Started | Date Completed | Total Hours | Number Enrolled | Number Passed |
|---|----------------|-------------|-----------------|---------------|
| Number: <input type="checkbox"/> Advanced <input type="checkbox"/> Basic <input type="checkbox"/> Pediatric <input type="checkbox"/> Recert <input type="checkbox"/> Recert <input type="checkbox"/> Access <input type="checkbox"/> Instructor <input type="checkbox"/> Instructor <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> _____ Total Students </div> <div style="text-align: center;"> _____ Total Students </div> <div style="text-align: center;"> _____ Total Students </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"> _____ Advanced Students X \$27 = \$ _____ </div> <div style="text-align: center;"> _____ Basic Students X \$17 = \$ _____ </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"> _____ Pediatric Students X \$15 = \$ _____ </div> <div style="text-align: center;"> _____ Instructor Students X \$27 = \$ _____ </div> </div> <div style="margin-top: 10px;"> \$ _____ Total Enclosed </div> | | | | |

Responsible party for payment of fees (if not enclosed): _____

Mail Cards & Certificates to: _____

Attention: _____

Complete Address: _____

Phone number: _____

The following items have been sent to the Chapter Office:
Please put an "X" after each item enclosed

1. Typed course roster _____ (Typed list of participants' names, addresses, provider level, test scores)
2. Typed faculty roster with assignments _____
3. Course Evaluation summary _____
4. Payment of fees _____

For office use only

| | |
|-------------------------------|------------------------------------|
| Date paperwork received _____ | Date and amount fee received _____ |
| International fees paid _____ | IDPH CE site code _____ |
| Date cards mailed: _____ | |