Wilderness Medicine Field Course (WMFC)

Registration

(1) Course Date: ________________ **Location:** __________________________

(2) Student Name: ____________________________________

(3) Address: ____________________________________

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(4) Telephone: ____________________________________

(5) Mobile Phone: ____________________________________

(6) Email Address: ____________________________________

(7) Circle one of the following:

(a) Medical Student — *(f) Climber*

(b) Doctor — *(g) Kayaker*

(c) Tri-athlete — *(h) Guest*

(d) *Adventure Racer* — *(i) Other* ______________________

(e) First Responder

(8) Medical School or Group Affiliation: __________________

(9) Please specify your sports interests (if any): __________________

(10)* Will you be taking the class for the first time**? ………………………………………… ***Yes No

(11) Do you have any medical conditions that could put you in danger in a remote wilderness environment? ……………………………………………………………… ***Yes No***

If Yes - please explain: ____

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(12)* Do you have a current CPR certification? ……………………………………………………** ***Yes No

(13)* Are you interested in a Wilderness First Responder Certification? …………………** ***Yes No

FOR PHYSICIANS:

(14)* Are you a physician? ………………………………………………………………………………** ***Yes No

(15)* Are you in AMA? …………………………………………………………………………………** ***Yes No

(16)* Are you in ACEP? ………………………………………………………………………………** ***Yes No

____ __________________

Please Sign & Date

RETURN COMPLETED FORM VIA eMAIL: WildMedMD@comcast.net

Your registration becomes active when course director receives your registration fee and liability form.

If you have any questions, please email or call Dr. Smith, MD at 301-524-6911