



2026 Course Registration Form

Live-streaming (Online):

HMTT, WC, HSD, and HFM (Module 1)

In-person (Jacksonville, FL):

HFM (Module 2) and Acrylics

Registration deadline is 10 days prior to the course date (12 noon Central Time).

Please Email or Fax this form to us before the deadline.

PLEASE SELECT YOUR COURSE DATES

Hyperbaric Medicine Team Training / Wound Care Course

Hyperbaric Medicine Team Training (HMTT - 5 days) \$975			The Wound Care Course (WC - 2 days) \$375		
Jan	12-16	(Mon-Fri)			
Feb	2-6	(Mon-Fri)	Feb	7-8	(Sat-Sun)
Mar	9-13	(Mon-Fri)			
Apr	13-17	(Mon-Fri)	Apr	11-12	(Sat-Sun)
May	4-8	(Mon-Fri)			
Jun	8-12	(Mon-Fri)	Jun	13-14	(Sat-Sun)
Jul	13-17	(Mon-Fri)			
Aug	10-14	(Mon-Fri)	Aug	15-16	(Sat-Sun)
Sep	14-18	(Mon-Fri)			
Oct	5-9	(Mon-Fri)	Oct	10-11	
Nov	9-13	(Mon-Fri)			(Sat-Sun)
Dec	7-11	(Mon-Fri)	Dec	12-13	(Sat-Sun)

Attendance requirement for HMTT:

☐ I understand the following: (1) I must be visible on camera during lectures; and (2) I cannot be driving or engaged in other activities such as patient care; and (3) I must attend the entire course to complete it.

Hyperbaric Safety Director Course / Acrylics

Safety Director Course (HSD - 3 days) \$495			Hyperbaric Chamber Acrylics (AC - 1 day) \$200		
Jan	26-28	(Mon-Wed)			
Jun	22-24	(Mon-Wed)	Feb	28	(Sat)
Sep	28-30	(Mon-Wed)	Oct	24	(Sat)

Hyperbaric Facility Maintenance: Module 1 & 2

Module 1 (HFM1 - 2 days) \$400			Module 2 (HFM2 - 1 day) \$200		
	Live-streaming Online			Jacksonville, FL	**Travel Required **
	Feb 20-21	(Fri-Sat)		Feb 27	(Fri)
	Oct 16-17	(Fri-Sat)		Oct 23	(Fri)

***Module 1 required to register for Module 2**

If you are completing this form for the participant

Name: _____
Phone Number: _____
Email: _____

Submit Registration Form & Fee To:

International ATMO, Inc.
Education Department
10134 Jandre Place
San Antonio, Texas 78213
(210) 614-3688 • FAX (210) 223-4864
education@hyperbaricmedicine.com

FOR OFFICE USE ONLY

Payments: ☐ Check ☐ Credit Card Invoice #:

Entered: _____ Check #: _____

Participant Information

Email: _____
** (Must have participant email address to register) **

Name: _____

As you want it to appear on documents _____

Credential (MD, RN, etc.): _____

As you want it to appear on documents _____

Mobile Phone: _____

Work Phone: _____

Mailing Address

Please provide a HOME address, not a hospital address.

Shipping Address: _____

City, State, Zip/Postal Code: _____

Country: _____

Canadian residents will be charged an additional \$35.00 USD for shipping of course materials.

Physicians (MD, DO, MBBS Only)

This information is necessary for proper reporting of CME credit.

License ID# or NPI: _____ State: _____

Birth Month/Day (MM/DD): _____ (do not include the year)

☐ I hereby give the UHMS permission to submit my CME credit to the PARS system.

Are you certified by an ABMS specialty board in the United States? ☐ Yes ☐ No

If "Yes", pick one:

☐ (ABA) Am Board of Anesthesiology	☐ (ABP) Am Board of Pediatrics
☐ (ABIM) Am Board in Internal Med	☐ (ABPath) Am Board of Pathology
☐ (ABOS) Am Board of Ortho Surgery	☐ (ABPM) Am Board of Preventive Med
☐ (ABOHNS) Am Board of Otolaryngology- Head/Neck Surg	☐ (ABS) Am Board of Surgery
	☐ (ABTS) Am Board of Thoracic Surg
	☐ -- NOT LISTED --

If your Board is listed above, please give your personal Board ID#: _____

Nurses (including APRN)

This information is necessary to provide CNE credit.

License State/Number: _____ State: _____ License #: _____

CHT/CHS

Select your certification: ☐ CHT ☐ CHS

Certification #: _____

Payment Information

A \$25.00 administrative fee will be retained from cancelled registrations.

Canadian residents will be charged an additional \$35.00 USD for course material shipping.

Discount Code (if applicable): _____

Method of Payment:

☐ Check (attached)
☐ Check (please invoice me) PROVIDE INFO BELOW
☐ Credit Card (please invoice me) PROVIDE INFO BELOW

Make checks payable to International ATMO, Inc.

If someone other than the registrant is paying the tuition, please complete the information below.

P.O. Number: _____
(if applicable)

Who will pay: _____

Contact Person: _____

Phone Number: _____

Email: _____