

American Heart Association Emergency Cardiovascular Care Program Course Roster

Please print or type all information

Course Information

New Students

Renewed Students

Type of Course: (A separate roster must be completed for each course –check only one.)

Heartsaver First Aid, CPR, AED includes: First Aid Basics: Medical, Injury, & Environmental Emergencies; Adult CPR AED (with a mask)

Designate Module(s) Taught Optional Modules: Child CPR/AED Infant CPR Written Test

Heartsaver CPR AED includes: Adult CPR, AED (with a mask); Adult Choking;

Designate Module(s) Taught Optional Modules: Child CPR/AED Infant CPR Written Test

Heartsaver First Aid includes: First Aid Basics; Medical, Injury and Environmental Emergencies **Optional Module:** Written Test

Heartsaver Pediatric First Aid: A= Pediatric First Aid **B=** Asthma Care Training for Childcare Providers

Designate Module(s) Taught C= Optional Pediatric First Aid Topics **D=** Adult/CPR w/Mask **E=** Adult/Child AED **F=** Infant CPR w/Mask

Heartsaver First Aid, CPR, AED, Schools

Heartsaver Instructor

Heartsaver Training Center Faculty

BLS Healthcare Provider

BLS Instructor

BLS Training Center Faculty

Other: Skills Check w/on-line Certificate:

ACLS Provider

ACLS Instructor

ACLS EP

ACLS EP Instructor

ACLS Training Center Faculty

PALS Provider

PALS Instructor

PALS Training Center Faculty

PEARS Provider

PEARS Instructor

BLS Challenge (Test and Skills Check) Guidelines Update: BLS ACLS PALS

Course Location: _____

Start Date/Time: _____ **End Date/Time:** _____ **Total Hours Instruction:** _____

Number of Instructors: _____ **Number of Students:** _____ **Number of Manikins:** _____ Adult _____ Child _____ Infant

Number of Students who began course: _____ **Number of Students who completed course:** _____

Manikins/Equipment Decontaminated by: _____

Instructor Information (Lead Instructor or Course Director)

Instructor Name: _____ **ID #:** _____ **Instructor Level:** _____ **Expiration Date:** _____

Home/Mailing Address: _____ **TC Registration:** _____

City/State/Zip: _____ **Home Phone #:** _____ **Work Phone #:** _____

Instructor Email Address (REQUIRED): _____

Assistant Instructor's Name	Instructor Card Expiration Date	Module/Station	List TC Affiliation, if you are not a member of this TC. (Attach a copy of your Instructor card. Both sides.)

For additional BLS Instructors and all ACLS and PALS Courses, use attached sign –in sheet for assisting instructors

Monitor's Name	Instructor Level	TC Affiliation	Complete Address

**** Monitors, please note (*) those Instructors you are monitoring, complete an Instructor Monitor form and attach to roster ****

I verify that this information is accurate and truthful, and that it may be confirmed. This course was taught in accordance with AHA Guidelines.

Signature: Course Director/Lead Instructor: _____

AHA TRAINING CENTER INFORMATION

All AHA cards are mailed directly to the Training Site Coordinator for Classes conducted at TC designated sites.

For all other classes, AHA cards are mailed directly to the Lead Instructor/Course Director to address noted above.

Course cards will be issued to the Training Site Coordinator, Lead Instructor or Course Director upon receipt of completed Course Roster and payment of fees. Completed Student Evaluation forms, all student written examinations and Skills Testing Checklist are kept at Training Site.) Direct Bill sites will receive cards and business will be billed. If any invoices are more than 60 days old, new card requests will be held until previous invoices are paid.

Consortium Members

Non-Consortium Members

Card Fees: ALL Heartsaver, effective 10/3/17	\$19.00	\$ 20.00	Skills Check: \$25.00
BLS Provider	\$ 3.00	\$ 5.00	(includes cost of card)
ACLS and PALS Provider	\$ 7.00	\$ 12.00	
All Instructor Cards	\$15.00	\$ 25.00	
Training Center Faculty	\$15.00	\$ 25.00	

Card Cost: _____ **X # Cards Requested:** _____ = **Amount Due:** \$ _____

Make checks payable to: Mid-Carolina AHEC, Inc Training Center Mail to Post Office Box Only

<p style="text-align: center;">**** AHA Training Center ****</p> <p>Mid Carolina AHEC, Inc. Training Center PO Box 2049 (Mail to PO Box Only) 1824 Hwy 9 Bypass West Lancaster SC 29721</p>	<p style="text-align: center;">Billing Information for Designated Training Sites</p> <p>Agency Name: _____</p> <p>Contact Person: _____</p> <p>Address: _____</p> <p>Phone #: _____ Email: _____</p>
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Office Use Only	Date Received: _____	Dated Entered: _____	Date Cards Mailed: _____
	Check #: _____	Entered/Mailed By: _____	

COURSE PARTICIPANTS



Date: _____ Course: _____ Location: _____ Instructor: _____

Name and Email Please PRINT as you wish your name to appear on your card. Please PRINT email address LEGIBLY.		Address	Phone #	Hospital Employee (Y/N)	Complete/Incomplete (Y/N)	Remediation Provided/Date Completed	Written Exam Score
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	Email						
2.							
	Email						
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