

Please Return Roster To: **First Response of the Bluegrass, Inc.**
 (859) 219-9799 - Office **828 Lane Allen Dr. Suite 180**
 (859) 219-9790 – FAX **Lexington, KY 40504**
www.first-response.org **firstresponse@windstream.net**

-----OFFICE USE ONLY-----

CT _____
 NC _____
 RC _____



American Heart Association Emergency Cardiovascular Care Program Course Roster

- | | |
|--|---|
| <input type="checkbox"/> BLS Healthcare Provider | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> BLS Instructor | <input type="checkbox"/> Initial |
| <input type="checkbox"/> Bloodborne Pathogens | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> First Aid Adult | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> First Aid Peds | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> Heart Saver CPR Family & Friends | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> Heart Saver CPR in Schools | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> Heart Saver CPR | |
| <input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Infant <input type="checkbox"/> AED | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> ACLS Provider | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> ACLS Instructor | <input type="checkbox"/> Initial |
| <input type="checkbox"/> ACLS EP Provider | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> ACLS EP Instructor | <input type="checkbox"/> Initial |
| <input type="checkbox"/> PALS Provider | <input type="checkbox"/> Initial <input type="checkbox"/> Renewal |
| <input type="checkbox"/> PALS Instructor | <input type="checkbox"/> Initial |

Training Center Name: First Response of the Bluegrass, Inc.

Training Site Name _____

Course Location _____

Course Director _____

Lead Instructor _____

Last 4 digits of SS # _____

Current AHA PALS/ACLS Physician Instructor Available

Physician Name _____

Manikins Decontaminated by _____

Course Start Date/Time _____ Course End Date/Time _____ Total Hours of Instruction _____

Student to Manikin Ratio: _____ Number of Cards Issued _____ Was Every Student Issued a Card? YES NO

Assisting Instructors / Specialty Faculty PRINT YOUR NAME , IF WE CAN'T READ IT NO TEACHING CREDIT !!

<i>Name</i>	<i>Inst. Card Exp Date</i>	<i>last 4 digits of SS#</i>	<i>Name</i>	<i>Inst. Card Exp Date</i>	<i>last 4 digits of SS#</i>
1.			2.		
3.			4.		
5.			6.		
7.			8.		

I verify that this information is accurate and truthful and that it may be confirmed. This course was taught within AHA guidelines.

 Lead Instructor's Signature

 Lead Instructor's PRINTED Name

 Date of course

 Email Address

Course Participants**-----INSTRUCTOR USE ONLY-----**

PPRINT LEGIBLY your name as you wish it to appear on your card.	Address	Phone	Have you had this class Before?	Examination Score REQUIRED	Card Number Required	Course Completed	Date Card Issued
1.			Y N			Y N	
2.			Y N			Y N	
3.			Y N			Y N	
4.			Y N			Y N	
5.			Y N			Y N	
6.			Y N			Y N	
7.			Y N			Y N	
8.			Y N			Y N	
9.			Y N			Y N	
10.			Y N			Y N	