

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS
NEONATAL RESUSCITATION REGISTRATION FORM
FOR CLASSES BEING HELD FROM January – December 2009

Course Location	Time	Date	Date

Check one
NRP Status:
 Expired or Initial
 Renewal



All registration must include a CURRENT Healthcare Provider CPR card. NRP renewals must submit a current copy of their CURRENT NRP as well as a Current Healthcare Provider CPR card in order to complete registration process. Failure in doing so will result with an incomplete registration and unconfirmed class.

Name: (please print clearly) _____ SBHCS Employee ID # _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Email Address:** _____

In order to qualify for the SBHCS Employee fee, a photocopy of your hospital ID card MUST accompany this form

Applicants outside of SBHCS	SBHCS In-system Employees
_____ \$225 Initial or Expired Applicants; (textbook included) _____ \$175 Renewal Applicants (NO text included)	_____ \$200 Initial or Expired Applicants; (textbook included) _____ \$150 Renewal Applicants (NO text included)

COMPLETE THIS SECTION ONLY IF YOU ARE SUBMITTING PAYMENT

Mail Payment to: NBIMC CPR Department ♦ 201 Lyons Avenue ♦ Newark, NJ ♦ 07112

Amount Enclosed: _____

Make check/Money order payable to: NBIMC CPR Dept.

FORM OF PAYMENT: Check # _____ Money Order # _____

Credit Card/Debit Card with Visa/Master card logo only **Type:** Master Card or Visa *(please circle)*

Credit Card # _____

Exp. Date: (MM/YY) _____ 3-digit security code on back of card: _____

(Signature required for all card Payments) Signature: _____

You may fax your registration and call the office to give this information if you choose to pay by credit or debit card.

COMPLETE THIS SECTION IF YOU ARE A SBHCS EMPLOYEE AND YOUR EMPLOYER IS PAYING THE COURSE FEE AND AUTHORIZING YOU TO ATTEND THIS PROGRAM

Hospital Affiliation: _____ Department: _____ Cost Center # _____

Please be advised that the cards will be mailed to each applicant at the address listed above; it is the responsibility of the Department to follow up with the employee to get a file copy of the card. Also, please be advised that there is a \$10.00 card replacement fee for misplaced or lost cards.

Director/Manager Signature: _____ Print Name: _____

This section has the option to: Fax # 973-923-6437 or send via interoffice Mail at NBIMC/CPR

The Community Training Center will review this registration upon receipt; you will be notified shortly via mail regarding your course selection.