ACLS-EP REGISTRATION FORM

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS

This form is for the Experinced Provider course only

[ ] **MUST submit copies of current ACLS and BLS Healthcare Provider cards**

Course Date: ____________________ ACLS-EP ONLY

Location: ____________________

Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________

Work Phone: ____________________

YOU MUST COMPLETE ONE OF THE TWO SECTIONS BELOW

COMPLETE THIS SECTION ONLY IF YOU ARE SUBMITTING PAYMENT

Non-Employees of Saint Barnabas Healthcare System

☐ **$225.00** *(Renewal with Experienced Provider book)*

Employees of Saint Barnabas Healthcare System

☐ **$200.00** *(Renewal with textbook)*

Make check/moneyorder payable to: **NBIMC CPR DPT.**

Amount Enclosed: __________ **Check/Money Order#** __________

Mail To: NBIMC CPR Department
201 Lyons Avenue
Newark, New Jersey 07112

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

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 advise that the cards will be mailed to each participant; it is the responsibility of the Department to follow up with the employee to get a copy for the file. Also, please be advised that there is a $10 card replacement fee for misplaced or lost cards.

Director/Manager Signature: ____________________

Name: ____________________

Fax to: (973) 923-6437

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201 Lyons Avenue
Newark, New Jersey 07112