

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS

# Advanced Cardiac Life Support Registration Form

For classes held from January 2009 – December 2009

Check one  
**ACLS Status:**  
 Expired or Initial  
 Renewal

<u>Course Location</u>	<u>Time</u>	<u>Date: Day 1</u>	<u>Date: Day 2 (if applicable)</u>
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Initial/Expired Registrants must forward a current copy of **BLS** card in order to complete registration process.  
 Renewals must submit current copies of **BLS** and **ACLS** cards 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 REQUIRED** \_\_\_\_\_

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
____ \$300 (Initial or Expired Applicant; textbook included)	____ \$250 (Initial or Expired Applicant; textbook included)
____ \$225 (Renewal Applicant; textbook included)	____ \$200 (Renewal Applicant; textbook included)
____ \$200 (Renewal Applicant, without textbook)	____ \$175 (Renewal Applicant; without textbook)

### 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, AMEX 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: \_\_\_\_\_

### 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 advise 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