

BLS FOR HEALTHCARE PROVIDER REGISTRATION FORM

FOR CLASSES BEING HELD FROM January 2009 - December 2009

YOU MUST INDICATE FIRST, SECOND AND THIRD CHOICES OF CLASS LOCATION AND DATE

	<u>Location</u>	<u>Time</u>	<u>Date</u>	<u>Please circle below</u>
First Choice:		____-____	____/____/____	Initial (or) Renewal
Second Choice:		____-____	____/____/____	Initial (or) Renewal
Third Choice:		____-____	____/____/____	Initial (or) Renewal

RENEWALS must forward a current copy of their BLS card with the registration form in order to complete the registration process. Failure in doing so will be an incomplete registration and unconfirmed

Name: (please print clearly) _____ **SBHC\$ EMPLOYEE ID REQUIRED** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Email Address:** _____

Applicants outside of SBHC\$	SBHC\$ In-system Employees
____ \$80. (Initial/Expired – Textbook included)	____ \$65. (Initial/Expired – Textbook included)
____ \$65. (Renewal with Textbook)	____ \$55. (Renewal with Textbook)
____ \$60. (Renewal without Textbook)	____ \$50. (Renewal 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:** _____

Card Holder Signatures _____

(Signature required for all Card Payments)

COMPLETE THIS SECTION IF YOU ARE A SBHC\$ 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

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