

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS

HEARTSAVER

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

First Choice: Location: _____ Date: _____

Second Choice: Location: _____ Date: _____

Third Choice: Location: _____ Date: _____

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

Course Fees: Non-SBHCS Employee: \$50 SBHCS E \$40

Amount Enclosed: _____ Check #: _____

Make Checks Payable To: **NBIMC CPR Department**

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

In order to qualify for the SBHCS Employee fee, a photocopy of your 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: _____

Director/Manager Signature: _____

Print Name: _____

Director/Manager _____

Fax to: (973) 923-6437

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