

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS
Pediatric advanced life support registration form
FOR CLASSES BEING HELD FROM January 2009 –December 2009

Check one
PALS Status:
 Expired or Initial
 Renewal

<u>Course Location</u>	<u>Time</u>	<u>Date: Day 1</u>	<u>Date: Day 2 (if applicable)</u>
------------------------	-------------	--------------------	------------------------------------



*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 **PALS** cards in order to complete registration process.
 Failure in doing so will result with an incomplete registration and unconfirmed class.*

Name: (please print clearly) _____

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 Applicants; textbook included)	____ \$250 (Initial or Expired Applicants; textbook included)
____ \$225 (Renewal with Textbook)	____ \$200 (Renewal with Textbook)
____ \$200 (Renewal without textbook)	____ \$175 (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: _____

(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 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