



TRAINING CENTER Registration Form

Name _____

Mailing address _____

E-mail address _____

Professional License # _____

Work phone number _____

Home or cell phone number _____

Required for non-associates (information used for databasing purposes only):

Birth Month ____ ____, **Birth Day** ____ ____, **Last 4 digits of SSN** ____ __ __ __

COURSE	COURSE DATE	COURSE TIME		COURSE	COURSE DATE	COURSE TIME
ACLS Accelerated				CPR Renewal		
ACLS Preparatory				EMS Refresher		
ACLS Provider				ENPC		
ACLS Renewal				NRP Provider		
AMI 12 Lead				NRP Renewal		
Basic Dysrhythmia				PALS Provider		
CPR Accelerated				PALS Renewal		
CPR Provider				TNCC		

Send form and payment to Barbara Couch:

E-mail address: barbara.couch@health-first.org

Inter-Office: Training Center, Rivercrest

Mailing Address: Health First Training Center
3470 N. Harbour City Blvd.
Melbourne, FL 32935

Phone: (321) 434.1972

Fax: (321) 254.0795

Payment options are as follows and payment must be submitted with registration form:

- 1) Cash or money order
- 2) Personal check payable to HF Training Center
- 3) Attach completed payroll deduction form
- 4) Credit card – MC, Visa, Discover

Expiration date: _____
- 5) Cost center transfer-not available for CPR or ACLS
Manager signature: _____
Cost center number _____ - _____ - _____

By signing this form, I know my registration fee will be forfeited or a \$10.00 fee will be deducted from my paycheck for free programs if I fail to cancel my registration within 48 hours of the start time of the course. A \$10.00 fee will be charged to process all refunds.

Signature (Required) _____

Date _____