

# Understanding Hemodynamics for the Novice Critical Care Nurse



**Target :** Nurses responsible for caring for critically ill patients. **Note\*** Critical Care Interns are **required** to attend 1 session

**Speaker:** Shari Rhymer, RN, CCRN

**Purpose:** The purpose of this program is to provide novice Critical Care Nurses with the knowledge and skills necessary to understand the underlying principles and mechanics of hemodynamic monitoring.

**Location:** Health First Center for Learning, Rivercrest

**Date/Time:** **Friday, March 23, 2012**                      **8:30AM-12:00PM**  
**Friday, July 13, 2012**                              **8:30AM-12:00PM**  
**Thursday, November 5, 2012**                      **8:30AM-12:00PM**

**Cost:** No cost to Health First Associates; \$35.00 for non-Health First associates

**Credit:** This program has been approved by Florida Board for **3.0 contact hours** of continuing education credit. Provider: Health First Center for Learning, Provider Number NCE 2046

**Confirmation:** Available through self-service People Soft HRMS ([Home](#) > [Self Service](#) > [Learning and Development](#) > [Training Summary](#)) . Please allow 3 business days before confirming your registration. For more information, contact Linda Keller at (321) 434-1963 or Angelika Warren (321) 434-1977 or email to [angelika.warren@health-first.org](mailto:angelika.warren@health-first.org)  
**Fax Registration to: 321-254-5151.**

**Registration: Hemodynamics**  
Registration deadline: 3 days prior to program date

Select the class you will attend: **Mar 23, 2012** \_\_\_\_\_ **July 13, 2012** \_\_\_\_\_ **Nov 5, 2012** \_\_\_\_\_

Name	Title	
Mailing address	License #	
City, state, zip	Phone H	W
Employment facility/unit	User ID:	
E-mail		

**Cancellation/Fees:** By signing this registration form I acknowledge that if I cancel my registration, I must do so at least 48 hours before the program begins. If this program is of no cost to me and I do not cancel 48 hours in advance, a \$10 fee will automatically be deducted from my paycheck.

**Signature (Required)** \_\_\_\_\_

\*Compliance with Health First dress code is expected.

<b>OFFICE USE ONLY: NO SHOW FEE \$10.00</b>		
Authorized by: _____	54 CFL – Revenue	050 600002 6400
Date: _____	55 CFL – Sponsorship	050 765830 6400