Mobile Health Service -- MHS Education Course Application

MHS Education Division, 1 RWJ Place, Box 2601,
New Brunswick, NJ 08903-2601
Office 732-937-8686 | Fax 732-418-8199 | www.rwjuh-mhs.org

ACLS Refresher by challenge or computer 2014

MegaCode testing session: [ ]1/30 [ ]2/23 [3/28 [ ]4/13 [ ]5/28 [ ]6/09 [ ]7/10 [ ]8/24
[ ]9/22 [ ]10/24 [ ]11/23 [ ]12/08 [ ]Private evaluation appointment to be mutually arranged

Optional selections:
[ ] ECG review on _____
[ ] Pharmacology review on _____
[ ] BLS renewal skills validation (additional $37.00 with AHA BLS for Healthcare Providers Part One Certificate)
[ ] Private appointment for MegaCode evaluation ($75.00)

Optional Text Options: [ ] Purchase from RWJUH ($33.50)
[ ] Will pick-up at MHS [ ] Send by U.S. Mail [ ] Send interoffice to dept. listed at right

Required attachments:
[ ] Valid BLS for Healthcare Providers card or
[ ] BLS pending at RWJUH on _____
[ ] Valid AHA ACLS Provider card
[ ] Payment, credit card info, or EMS Education Waiver Application

Registration acknowledgement by: [ ] E-mail or [ ] Telephone

Cancellation Policy: If RECEIVED less than ten BUSINESS DAYS before the course--NO REFUND. If RECEIVED 10 or more business days before the course--full refund if the issued material(s) are returned in brand new condition prior to the start of the course.

I checked that the above information is correct, understand and acknowledge the cancellation policy, and will bring a current textbook to class. Register me.

SIGN HERE ► _____

Office Use Only: Acknowledged [ ] in person by [ ] phone [ ] e-mail.
Student [ ] absent [ ] incomplete [ ] cancelled on_____ [ ] verbally [ ] in writing.
[ ] CC Billed [ ] CC Rejected [ ] EW attached [ ] EW billed [ ] Invoiced [ ] Training Fund billed
DATE RECEIVED (Form saved 12/11/13, printed 12/11/13)

Forms that are incomplete or without payment will not be processed.

Name (Please print clearly.)

E-mail address (This is our default written communication.)

Address			
Day phone		Cell phone	
Eve phone		EMS ID#	

Circle your healthcare professional role/level:
MD/DO DDS/DMD PA APN RN LPN RespTx PhysTx MedStudent Paramedic EMT FR/FF/PD ATC Pharm CCT Other_____

New Brunswick healthcare campus affiliation, if applicable:
[ ] RWJUH [ ] UMDNJ-RWJMS Unit/Department_____
Check, if appropriate: [ ]Resident [ ]Fellow [ ]Faculty [ ] MedStudent

PAYMENTS: Tuition $130 Additional: [ ]Text $33.50 [ ]BLS Renewal $37 [ ]Private evaluation $75 TOTAL: $_____
CHECK OR MONEY ORDER payable to Robert Wood Johnson University Hospital
#_____ $_____

CREDIT CARD	Circle one: AmericanExpress MasterCard Visa Discover		
Cardholder's Name	[ ] Same as above		
Cardholder's Address	[ ] Same as above		
Card Number			
Expiration Date		CVV or Security code	

Please read and sign below this statement: I agree to pay the total amount noted above per the card issuer agreement.
Cardholder Signature_____