Mobile Health Service -- MHS Education Course Application

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

Skill Validation for Renewal of BLS for Healthcare Providers Wednesday, October 15, 2014

Select the preferred hour for your skill demonstration appointment:
[ ] 3:30 pm [ ] 4:00 pm [ ] 4:30 pm [ ] 5:00 pm [ ] 5:30 pm [ ] 6:00 pm [ ] 6:30 pm
[ ] 7:00 pm [ ] 7:30 pm [ ] 8:00 pm [ ] 8:30 pm [ ] 9:00pm

Optional Text: [ ] Purchase from RWJUH ($12.00) [ ] No thanks.

Required attachments:
[ ] Copy of your valid AHA BLS for Healthcare Providers, ARC CPR/AED for Professional Rescuers and Health Care Providers, or NSC professional-level CPR card being renewed
[ ] Part One Certificate printed after completion of on-line coursework at www.OnLineAHA.org
[ ] Payment, credit card info, or EMS Education Waiver Application

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

Course Materials Delivery:
[ ] Pick-up M-F 8:30 a.m.-5:00 p.m. at RWJUH EMS Education, 126 Paterson Street in New Brunswick (Recommended if registering within 2 weeks of course.)
[ ] U.S. mail to registration address. (This may take 10 days to 2 weeks.)
[ ] Interoffice/intercampus to RWJUH or UMDNJ unit/department:_____

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

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 $37.00 Additional: [ ]Text $12.00 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_____