



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, September 17, 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	<input type="checkbox"/> Same as above		
Cardholder's Address	<input type="checkbox"/> 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 _____