

Please make checks payable to: Lowcountry Regional EMS

Lowcountry Regional EMS Council CTC

PAYMENT: CHECK ___ CASH ___ BILL ___ Phone: (843) 529-0977 Fax: (843) 529-0460

Mail Rosters & Processing Fees To:

INCOMPLETE ROSTERS WILL BE RETURNED

CC# _____

1016 East Montague Avenue
North Charleston, SC 29405

EXPIRATION: _____ CVZ# _____

E-Mail: lisa@lowcountryems.com

<u>Type of Course:</u> (Check only one course per roster. New and Renew for same course is acceptable.)				
<input type="checkbox"/> BLS Healthcare Provider (\$5.00)	<input type="checkbox"/> HS 1 st Aid, CPR, AED (check all that apply) (\$5.00)	<input type="checkbox"/> ACLS Provider (\$7.00)		
<input type="checkbox"/> HS CPR AED (check all that apply) (\$5.00)	<input type="checkbox"/> Child CPR AED	<input type="checkbox"/> PALS Provider (\$7.00)		
<input type="checkbox"/> Child CPR AED	<input type="checkbox"/> Infant CPR	<input type="checkbox"/> ACLS EP Provider (\$7.00)		
<input type="checkbox"/> Infant CPR	<input type="checkbox"/> Written Test (optional)	<input type="checkbox"/> BLS Instructor (\$9.00)		
<input type="checkbox"/> Written Test (optional)	<input type="checkbox"/> HS Pediatric 1 st Aid (check all that apply) (\$5.00)	<input type="checkbox"/> Heartsaver Instructor (\$9.00)		
<input type="checkbox"/> Heartsaver 1 st Aid (\$5.00)	<input type="checkbox"/> Asthma Care Training for Childcare Providers	<input type="checkbox"/> ACLS Instructor (\$9.00)		
<input type="checkbox"/> Written Test (optional)	<input type="checkbox"/> Optional Pediatric 1 st Aid Topics	<input type="checkbox"/> PALS Instructor (\$9.00)		
<input type="checkbox"/> Family & Friends N/C	<input type="checkbox"/> Adult/Child CPR w/Mask	<input type="checkbox"/> ACLS EP Instructor (\$9.00)		
	<input type="checkbox"/> Adult/Child AED			
	<input type="checkbox"/> Infant CPR w/Mask			

Course Date: _____ Course Hours: _____ Student Manikin Ratio: _____ Course Location: _____

Number of **New** students: _____ Number of **Renewing** students: _____

Instructor Information: (Please print all unless otherwise instructed) *If required

Instructor's Printed Name: _____ **Instructor's Signature:** _____

***Affiliate Faculty:** _____ ***Affiliate Faculty Signature:** _____

My signature attests that the course listed was taught in accordance with the policies and procedures set forth by the American Heart Association and Lowcountry Regional EMS CTC.

Home Address: _____ Home #: _____

Work #: _____

Cellular#: _____

E-Mail address: _____

Comments: _____

Mail cards to: _____ _____ _____ _____

Assisting Instructors:

Name of Instructor	Assisting Instructor Signatures	Home CTC	Renewal Date	Monitored
1. _____	_____	_____	___/___/___	Yes No
2. _____	_____	_____	___/___/___	Yes No
3. _____	_____	_____	___/___/___	Yes No

(Additional Instructors should be listed on a separate sheet and attached to this document)

Lowcountry Regional EMS Council Roster
PLEASE PRINT (Illegible names will not be processed)

	new or renew	First Name	MI	Last Name	Address	Phone #	Post- Test	Skills verified
EX:	N	John	R.	Doe	123 Any Street, City, State, Zip johnrdoe@email.com	843-555-1212	100	X
1)					email:			
2)					email:			
3)					email:			
4)					email:			
5)					email:			
6)					email:			
7)					email:			
8)					email:			
9)					email:			
10)					email:			
11)					email:			
12)					email:			
13)					email:			