HeartCode ACLS is the AHA’s blended learning delivery method for the AHA’s ACLS Course. Blended learning is a combination of eLearning, in which a student completes part of the course in a self-directed manner, followed by a hands-on session.

Designed for the Advanced Healthcare Provider seeking a new or renewal ACLS Certification

### Hands-On Skills Sessions – 2:30 p.m. to 4:30 p.m.

<table>
<thead>
<tr>
<th></th>
<th>January 24</th>
<th>February 21</th>
<th>March 27</th>
<th>April 24</th>
<th>May 29</th>
<th>June 26</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>July 24</td>
<td>August 21</td>
<td>September 25</td>
<td>October 23</td>
<td>November 20</td>
<td>December 18</td>
</tr>
</tbody>
</table>

*Heartcode hands-on skills sessions require the completion of the American Heart Association Heartcode ACLS online program.*

### Cost

<table>
<thead>
<tr>
<th></th>
<th>Health First Associates: $132.00</th>
<th>Public Fees: $207.00</th>
</tr>
</thead>
</table>

*Registration and payment are required. Cost includes online course, eBook, eCard and hands-on skills session.*

### Course Prerequisite

- Students must be well prepared in advance of course
- Complete the Online Course
- Print and bring certificate of completion to the hands-on session
- Bring Photo ID

### Course Registration

To register, please complete registration form on the reverse side of this flyer and email/fax with course fee.

*Registered students will receive email confirmation of enrollment.*

### Address

All classes are held at the Health First Training Center, 3470 N. Harbor City Blvd., Melbourne, FL, 32935. We are located in the Rivercrest Professional Center on US Highway 1, between Post Road and Parkway Boulevard.

### Contact Information

Phone: 321.434.1960  Fax: 321.254.0795  E-mail: Training@HF.org
Student Information

Name: ________________________________________ User ID: __________________________

Mailing Address: _________________________________________________________________

City, State, Zip: ________________________________________________________________

Contact Phone: __________________________ Professional License #: ________________________

Email (Required): ________________________________________________________________

Course/Book Name __________________________ Course Date __________________________ Course Fee $ ______

________________________________________ ______________________ __   $________

Payment Options

□ Cash or Check (made payable to Health First Training Center) $________

□ Credit Card #______________________________________ Exp: ____ ______  CVV: _______ $________

□ Health First Associates Only — Payroll Deduction:
I authorize Health First to deduct over ____One ____Two ____Three
pay periods until the amount indicated is paid in full. $________

□ Cost Center Transfer (not available for CPR or ACLS): Cost Center #: ______ – ______________ – ________

Manager Signature: ______________________________     Print Name: __________________________________

Contact Information

Email Registration to Training@HF.org
Fax Registration to 321.254.0795
Health First Training Center
3470 N. Harbor City Blvd.
Melbourne, FL 32935
Phone: 321.434.1960

By signing this registration form, I acknowledge that if I cancel my registration, I must do so 48 hours prior to the program start time. Failure to cancel will result in the loss of my registration fee. Unless stated otherwise on program flyer, a $10 administrative fee will be charged for all refunds.

Health First Associates:

▪ If the registration fee is being paid by my department and I fail to cancel 48 hours prior to the program, I acknowledge that I will become responsible for the registration fee, which will be deducted from my paycheck.

▪ Failure to cancel your registration will result in a $10 charge, which will automatically be deducted from your paycheck.

▪ Exceptions for verifiable emergencies will be made on a case by case basis.

▪ I understand and agree that upon my severance of employment, whether voluntary or involuntary, any balance due for this deduction will be withheld from my final check and/or from pay out of accrued Personal Leave (PL).

Student Signature (Required) __________________________ Date __________________________

Office Use Only:
Authorized by: __________________________ Date: __________________________