Advanced Cardiac Life Support (ACLS) Provider 2020

Two-Day Provider – 9 a.m. to 5 p.m.
Designed for the New Healthcare Provider seeking initial ACLS Certification.

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<th>Month</th>
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Cost

- **Health First Associates:** Complimentary
- **Public Fees:** $150

Pre-registration and payment is required.

Course Prerequisites

- American Heart Association (AHA) requires that all students must have a current course textbook readily available for use.
- Students must be well-prepared in advance of course.
- Proficient at electrocardiogram (ECG) rhythm recognition
- Please bring a photo ID with you to your class.
- All students must complete the Mandatory Self-Assessment with a grade of 70% or higher found at Heart.org/ECCStudent (access code: acls15).
- Print your Self-Assessment results and show them to your instructor the day of course.

Course Registration

**Health First Associates:** To register, please go to the Health First intranet, hover over Education, click Online Learning and log in. Click Browse icon, click 2020 Training Center Courses, select the format and session you wish to attend, register by clicking Read Disclaimer, click Confirm button.

**Public Attendees:** 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

Contact Hours

- FL Board of Nursing, #NCE 2046 10 hours
- FL Board of Respiratory Care 10 hours
- Bureau of EMS 10 hours
- **AMA PRA Category 1 Credits™** 8 hours
Health First Training Center
Registration Form

Student Information

Name: ____________________________  User ID: ____________________________

Mailing Address: ____________________________

City, State, Zip: ____________________________

Contact Phone: ____________________________  Professional License #: ____________________________

Email (Required): ____________________________

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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: ____________________________