

Advanced Cardiac Life Support (ACLS) Renewal 2019

One-Day Renewal – 9:00 a.m. – 5:00 p.m.

Designed for the Healthcare Provider seeking to renew ACLS Certification.

January 11	February 14	March 8	April 3	May 2	June 6
January 19	February 20	March 16	April 18	May 10	June 12
January 30	February 26	March 27	April 24	May 18	June 19

July 12	August 14	September 6	October 11	November 8	December 13
July 20	August 22	September 14	October 16	November 20	December 18
July 31	August 30	September 25	October 30	November 23	

Cost Health First Associates: Complimentary
Public Fees: \$125.00

Pre-registration and payment required.

- Course Prerequisite**
- Must possess current American Heart Association (AHA) ACLS card.
 - 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: **ac15**).
 - 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 **Home** icon, search **ACLS**, 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@Health-First.org

Contact Hours FL Board of Nursing, #NCE 2046FL Board of 0 hours
Respiratory Care 4 hours
Bureau of EMS 4 hours
AMA PRA Cat. 1 Credit 4 hours

Health First Training Center Registration Form

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 Total Amount Due

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@Health-First.org

Fax Registration to 321.254.0795

Health First Training Center
3470 N. Harbor City Blvd.
Melbourne, FL 32905
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: _____