

Basic Dysrhythmia 2018

PROGRAM DESCRIPTION and OBJECTIVES

Learn: Rhythm Adult is an online, self-directed course that introduces healthcare providers to normal cardiac rhythms and prepares them to recognize basic cardiac arrhythmias in clinical practice.

This course features a combination of audio, animation, interactive activities, and self-assessments. It is self-paced and is completed entirely online. This course helps with ECG rhythm recognition, algorithm application, and patient treatment.

At the conclusion, participants should be able to:

- Summarize basic anatomy of the heart
- Identify components of the cardiac cycle, identify correct electrode placement, calculate heart rates
- Recognize normal sinus mechanism; differentiate arrhythmia from NSR, sinus bradycardia, sinus tachycardia
- Recognize premature beats: PAC, PJC, PVC
- Recognize core arrest arrhythmias
- Recognize core peri-arrest arrhythmias
- Describe and distinguish between the heart blocks

Target Audience	Healthcare professionals and telemetry staff who need basic rhythm recognition skills; students preparing for ACLS, such as paramedics/EMTs, nurses, physicians, clinical pharmacists and respiratory therapists.
	Learn: Rhythm Adult is a continuing education activity.
Cost	Health First Associate Fee: \$55.00 Public Fee: \$65.00 Pre-registration and Payment Required
Registration	See reverse side of flyer for registration form. <i>Registered students will receive e-mail confirmation of their enrollment, which contains their individual online program "access key" and instructions.</i>
Address	Health First Training Center, Rivercrest Professional Plaza, 3470 N. Harbor City Blvd. (US 1), Melbourne, FL 32935 (Located on US Highway 1 between Post Road and Parkway Boulevard)
Contact Information	Phone: 321.434.1960 Training@Health-First.org Fax: 321.254.0795 Inter-Office Mail: Training Center, Rivercrest
Cancellation	By registering for this online program, I acknowledge that my registration fee is forfeited immediately upon issue of the "online" access key.

Registration Form

Name:	Contact Phone: () -	
Mailing Address:	City: State:	
License Number:	Zip code:	
E-mail Address (required):		
Health First Associates Universal ID (Required) #: _____ Course Card Exp Date _____		
Non-Associates (Required): Birth Month ____ Birth Day ____ Last 4 digits of SSN ____		
Course Name(s) and/or Textbooks:	Course Date(s):	Fee:
Payment options are as follows and payment must be submitted with this registration form:		
Select One:		Amount Due:
<input type="checkbox"/> Cash, Check or Money Order (made payable to Health First Training Center)		
<input type="checkbox"/> Credit Card (MC, Visa, Discover, Amex): # _____ Exp. Date: _____ CVV _____		
<input type="checkbox"/> Health First Associates Only—Payroll Deduction: I authorize Health First to deduct over <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three pay periods until the amount indicated is paid in full.		
Cost Center Transfer: Manager Signature: _____ Cost Center #: _____ - _____ - _____	Send form with payment to: Health First Training Center 3470 N. Harbor City Blvd., Melbourne, FL 32935 E-mail address: Training@Health-First.org Phone: 321.434.1960 Fax: 321.254.0795	

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.
- If there is no fee to attend the program, failure to cancel will result in a \$10 charge which will automatically be deducted from my paycheck. **NOTE: 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 PL.

Signature (Required)

Date