

# BLS – Instructor Led Training

October - December 2018

## **CPR/Basic Life Support for New, Renewing and Expired Healthcare Provider Certification**

*American Heart Association Curriculum and Certification*

### **Classroom Course**

**Health First Associate and Public Fee:**      **\$65**  
(Includes textbook, classroom instruction and evaluation in the same session)

**Friday, October 19, from 5 to 9 p.m.**

**Saturday, December 8, from 8:30 a.m. to 12:30 p.m.**

**Textbook**                      Student textbook is included in the cost of the course and can be picked up at the Health First Training Center.

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**Registration**                      Please fill out registration form and return it via fax, scan/email, interoffice or mail. Make sure you indicate which session you would like to attend.

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**Registration Confirmation**                      It is the responsibility of each student to verify enrollment. If you do not receive a confirmation email, please contact us.

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**Location**                              Health First Training Center – Rivercrest  
3470 N. Harbor City Blvd., Melbourne, FL 32935

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**Contact Information**

- **Phone:** 321.434.1960
- **Fax:** 321.254.0795
- **Email:** [Training@Health-First.org](mailto:Training@Health-First.org)
- **Interoffice:** Health First Training Center, Rivercrest

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**Cancellation**                      Cancellations must be made 48 hours prior to program to avoid forfeiture of class fee. An administrative fee of \$10 will be deducted from all refunds.

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## Registration Form

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

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