American Heart Association Emergency Cardiovascular Care Programs
Basic Life Support for Healthcare Providers (BLS HCP)
Course Roster

Course Information

☐ **New Course**

☐ **Renewal Course**

Instructor _____

Training Center Interior Region EMS Council, Inc.
Training Center ID# AK03066
Training Site Name (FMH only) _____

Course Location _____
Address _____
City, State ZIP _____

Course Start Date/Time _____ Course End Date/Time _____ Total Hours of Instruction _____

No. of Cards to be Issued _____ Student-Manikin Ratio _____ Issue Date of Cards _____

Assisting Instructors *(Attach copy of instructor card for instructors aligned with a TC other than the primary TC)*

Name and Instructor ID#	*Card Exp. Date*	*Name and Instructor ID#*	*Card Exp. Date*
1.		5.	
2.		6.	
3.		7.	
4.		8.	

I verify that this information is accurate and truthful and that it may be confirmed. This course was taught in accordance with AHA guidelines.

_____ _____
Signature of Lead Instructor Date

Date _____ **BLS HCP Course** **Instructor _____**

Course Participants

Name and Email ***Please PRINT as you wish your name to appear on your card. Please print email address legibly.***		*Home Mailing Address*	*Telephone*	*Dept.* *(for FMH purposes)*	*Complete/ Incomplete*	*Remediation Date Completed (if applicable)*	*Exam Score* ***84%*** *or higher*
1. First Name	Last Name						
Email		City State Zip Code					
2. First Name	Last Name						
Email		City State Zip Code					
3. First Name	Last Name						
Email		City State Zip Code					
4. First Name	Last Name						
Email		City State Zip Code					
5. First Name	Last Name						
Email		City State Zip Code					
6. First Name	Last Name						
Email		City State Zip Code					
7. First Name	Last Name						
Email		City State Zip Code					
8. First Name	Last Name						
Email		City State Zip Code					
9. First Name	Last Name						
Email		City State Zip Code					
10. First Name	Last Name						
Email		City State Zip Code					