Date Recvd:_____ **SMC Roster #** _____ **(SMC Use Only)** **Course Date** _____

Via: Mail   Fax   Email   In-person

	Shore Medical Center Life Support Training Center **Basic Life Support and HeartSaver Course Roster**
One Type of Card per Roster	**Provider Company:** _____
____ BLS **Skills** Only(Certificate Required) Only one type of certificate per roster	Course **Physical Address** **or Name of School:**_____
Basic Life Support - $8 Jan-March 2024, $9.00 as of 4/1/24 ___ **BLS** 15-1805 Cards do NOT state "Healthcare Provider"	Start Time: _____ End Time: _____ Total Hours: _____ Lead Instructor: _____ Card Exp: _____ Phone: _____ Email: _____
HeartSaver Cards – $20 Jan-March 2024, $22.00 as of 4/1/24 _____ HS **Skills** ONLY (Cert.required - Must also Select Skill on list Below) ___**HS CPR/AED** 15-1810 ___**HS First Aid** 15-1811 ___**HS CPR/AED/First Aid** 15-1812	Assisting Instructor: _____ Card Exp.: _____ □Monitored Assisting Instructor: _____ Card Exp.: _____ □Monitored Assisting Instructor: _____ Card Exp.: _____ □Monitored Student to Manikin Ratio:_____ Student to Instructor Ratio:_____ **Payment Information**: Total # of students/cards:_____ Remittance: $_____
___ **Heartsaver for K-12 Schools** **$ 8 each** 15-1819 (no price increase in 2024) Instructor is responsible to mark cards with appropriate HS modules completed.	Check issued by:_____ Check #_____ Dated:_____ CC Auth. Signature/Last 4 digits: _____
___**Family and Friends – No cards**	PO Issued by: _____ Binding Purchase Order Attached - Number:_____

Instructor acknowledgment: I verify that this information is accurate and truthful and that it may be confirmed. **The course was taught in accordance with current AHA guidelines and with current materials.** All equipment utilized during the course was properly decontaminated in accordance with American Heart Association or manufacturer's standards. I agree to maintain copies of all rosters and make available upon request for a period of three years from date of course.

Manikin decontamination by: _____ **Signature Lead Instructor**:_____ _____

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Course Participants: Please Print Name and address clearly. There is a charge to reissue cards not clearly printed. Thank you.

Name and Email **Print Clearly or send typed list** as you wish it to appear on card	Complete Address Daytime Contact Phone # Including Area Code	<u>HS Only: Pass/Fail</u> BLS: **Exam Score,** **TestVersion**(Required)		Any required Remediation? Date Completed
		Score	Version	
1. name **Email**				
2. name **Email**				
3. name **Email**				
4. name **Email**				
5. name **Email**				
6. name **Email**				
7. name **Email**				

BLS/HS Course Roster Rev 1/2024   Shore Medical Center Life Support Training Center   Glenda Stogel, TC Administrator

TrainingCenter@shoremedicalcenter.org   100 Medical Center Way, Somers Point, NJ 08244   609-653-3962 (Phone)   609-926-4793 (Fax)

Date Recvd:_____ **SMC Roster #** _____ **(SMC Use Only)** **Course Date** _____

Via: Mail   Fax   Email   In-person

Course Participants: Please Print Name and address clearly. There is a charge to reissue cards not clearly printed. Thank you.

Name and Email **Print Clearly or send typed list** as you wish it to appear on card	Complete Address Daytime Contact Phone # Including Area Code	HS Only: Pass/Fail BLS: **Exam Score** **BLS Test Version** (Required)		Any required Remediation? Date Completed
8. name **Email**				
9. name **Email**				
10. name **Email**				
11. name **Email**				
12. name **Email**				
13. name **Email**				
14. name **Email**				