

ACLS 2012

Advanced Cardiac Life Support

Two Day Provider (ACL002) 9:00 am – 5:00 pm

Designed for the new and expired Healthcare Provider

January 12 - 13	July 11 - 12
March 13 – 14FULL	September 10 - 11
May 9 - 10	November 14 - 15

One Day Renewal Provider (ACL004) 9:00 am – 5:00 pm

Designed for the renewing provider who desires additional learning and practice time;
MUST possess current AHA ACLS Card.

Jan 12	Mar 13FULL	May 9	Jul 11	Sep 10	Nov 6
Jan 31	Mar 30	May 22	Jul 31	Sep 27	Nov 14
Feb 3	Apr 11	Jun 11	Aug 8	Oct 3	Dec 4
Feb 15FULL	Apr 30	Jun 26	Aug 28	Oct 25	Dec 12

Accelerated Renewal (ACL006) 9:00 am – 1:00 pm

For the experienced provider ONLY. Attendee MUST possess a current AHA ACLS Card.
There will be no remedial instruction offered or provided.

January 23	April 17	July 23	October 30
February 24	May 14	August 2	November 30
March 5	June 20	September 19	December 17

Health First Associate Fee: \$15.00

Public Fees:

Provider \$150.00, Renewal \$125.00, Accelerated Renewal \$100.00

****Pre-registration and payment required.**

Cost

Course Pre-Requisites

Students are strongly encouraged to prepare in advance of course date. All students must complete the pre-course assessment found at www.heart.org/eccstudent Access code: compression

The ACLS Provider Manual is available for \$40 at the Training Center.

Registration Confirmation

It is the responsibility of each student to verify enrollment.

Health First Associate: Confirmation is available through self-service PeopleSoft (just like viewing your paycheck) Self Service>Learning and Development>Training Summary

Address

All classes are held at the Health First Training Center, 3470 N. Harbor City Blvd., Melbourne 32935. We are located in Rivercrest Professional Center on US 1, between Post Rd. and Parkway Blvd.

Contact Information

Phone: (321) 434-1972

barbara.couch@health-first.org

Fax: (321) 254-0795

Cancellation

Cancellation must be made 48 hours prior to program to avoid forfeiture of class fee. An administrative fee of \$10.00 will be deducted from all refunds.

Contact Hours

	Provider	Renewal	Accelerated
FL Board of Nursing, #NCE 2046	10 hr	0	0
FL Board of Respiratory Care	10 hr	4 hr	1 hr
HRMC Category I CME credit	8 hr	4 hr	1 hr
Paramedic: Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS)	12 hr	5.25 hr	0 hr



TRAINING CENTER Registration Form

Name:	
Mailing Address:	City: State:
E-mail Address:	Professional License #:
Work/Dept.Phone:	Cell/Home Phone:
Health First Associates Universal ID (Required) # _____	
Non-Associates Birth Month ____ Birth Day ____ Last 4 digits of SSN ____	
Required (information used for databasing purposes only):	

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 (X)	Description	Amount Due
	Cash, Check or Money Order (Made Payable to HF Training Center)	
	Credit Card (MC, Visa, Discover): # _____ Exp. Date: _____	
	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) Manager Signature: _____ Cost Center #: _____ - _____ - _____	Send form and payment to Barbara Couch: Mailing Address: Health First Training Center 3470 N. Harbor City Blvd. Melbourne, FL 32935 E-mail address: barbara.couch@health-first.org Phone: (321) 434.1972 Fax: (321) 254.0795
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By signing this form, I agree my registration fee will be forfeited if I fail to cancel my registration within 48 hours of the start time of the course. A \$10.00 fee will be charged to process all refunds.

If I elected Payroll deduction, 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. Additionally, if this course is of no cost to me, and I fail to cancel within 48 hours as noted above, a \$10.00 fee will be deducted from my paycheck.

Signature (Required) _____ Date _____