

Mobile Health Service -- MHS Education Course Application
MHS Education, 1 RWJ Place, Box 2601, New Brunswick, NJ 08903-2601
Office 732-937-8686 | Fax 732-418-8199 | www.rwjuh-mhs.org

| EMT Review (NJ EMT Refresher Course "E")<br>October 25-26, 2014  |
|--|
| Reason for taking this EMT refresher: [] Renewing a current, valid EMT certification (renewal) [] Reactivation of an expired EMT certification (re-entry) [] Training in connection with EMT exam challenge (reciprocity) [] Prerequisite to retake the EMT exam after initial training (remediation)                      |
| Required attachments: [] Payment, credit card info, or EMS Education Waiver Application  |
| Registration acknowledgement by: [] E-mail or [] Telephone   |
| Course Materials Delivery:  [] Pick-up M-F 8:30 a.m5:00 p.m. at RWJUH EMS Education, 126 Paterson Street in New Brunswick (Recommended if registering within 2 weeks of course.)  [] U.S. mail to registration address. (This may take 10 days to 2 weeks.)  [] Interoffice/intercampus to RWJUH or UMDNJ unit/department: |
| Cancellation Policy: If RECEIVED less than ten BUSINESS DAYS before the courseNO REFUND. If RECEIVED 10 or more business days before the coursefull refund if the issued material(s) are returned in brand new condition prior to the start of the course.   |
| I checked that the above information is correct, understand and acknowledge the cancellation policy, and will bring a current textbook to class. Register me.  |
| SIGN HERE ▶  |

Office Use Only: Acknowledged [] in person by [] phone [] e-mail.

DATE RECEIVED

Student [] absent [] incomplete [] cancelled on\_\_\_\_\_ [] verbally [] in writing. [] CC Billed [] CC Rejected [] EW attached [] EW billed [] Invoiced [] Training Fund billed

(Form saved 1/13/14, printed 1/13/14)

Forms that are incomplete or without payment will not be processed.

| Name (Please p  | orint clearly.)                  |             |             |        |         |       |     |          |  |
|---|----------------------------------|-------------|-------------|--------|---------|-------|-----|----------|--|
|   |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     |          |  |
| E-mail address (This is our default written communication.)                                       |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     | <u> </u> |  |
| Address   |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     |          |  |
| _   |                                  | 1           |             |        |         |       |     |          |  |
| Day   |                                  | Cell        |             |        |         |       |     |          |  |
| phone   |                                  | phone       |             |        |         |       |     |          |  |
| Eve   |                                  | EMS         |             |        |         |       |     |          |  |
| phone   |                                  | ID#         |             |        |         |       |     |          |  |
| Circle your healthcare professional role/level:   |                                  |             |             |        |         |       |     |          |  |
| MD/DO DDS/DMD PA APN RN LPN RespTx PhysTx MedStudent Paramedic EMT                                |                                  |             |             |        |         |       |     |          |  |
| FR/FF/PD ATC Pharm CCT Other  |                                  |             |             |        |         |       |     |          |  |
|   |                                  |             |             |        |         |       |     |          |  |
| New Brunswick healthcare campus affiliation, if applicable:                                       |                                  |             |             |        |         |       |     |          |  |
| [] RWJUH [] UMDNJ-RWJMS Unit/Department   |                                  |             |             |        |         |       |     |          |  |
| Check, if appropriate: []Resident []Fellow []Faculty [] MedStudent                                |                                  |             |             |        |         |       |     |          |  |
| DAVMENTS: Tuition \$80.00   |                                  |             |             |        |         |       |     |          |  |
| PAYMENTS: Tuition \$80.00 CHECK OR MONEY ORDER payable to Robert Wood Johnson University Hospital |                                  |             |             |        |         |       |     |          |  |
| #\$   |                                  |             |             |        |         |       |     |          |  |
| πΨ  |                                  |             |             |        |         |       |     |          |  |
| CREDIT CARD   | Circle one: AmericanExpre        | ess Mas     | terCard     | Visa   | Discov  | er    |     |          |  |
| Cardholder's  | [] Same as above                 |             |             |        |         |       |     |          |  |
| Name  | [1] commo and and a              |             |             |        |         |       |     |          |  |
| Cardholder's  | [] Same as above                 |             |             |        |         |       |     | _        |  |
| Address   | [1] commo and and a              |             |             |        |         |       |     |          |  |
| 1 100   |                                  |             |             |        |         |       |     |          |  |
| Card  |                                  |             |             |        |         |       |     |          |  |
| Number  |                                  |             |             |        |         |       |     |          |  |
| Expiration  |                                  | CVV or      |             |        |         |       |     |          |  |
| Date  |                                  | Security    | code        |        |         |       |     |          |  |
| Please read and   | d sign below this statement: I a | agree to pa | y the total | amount | noted a | above | pei | r        |  |
| the card issuer   | agreement.                       | - '         | -           |        |         |       | •   |          |  |
| Cardholder Signature  |                                  |             |             |        |         |       |     |          |  |