ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL

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.rwiuh-mhs.org

Heartsaver CPR AED--2014

Date:

[] February 20 [] March 4 [] April 7 [] May 5 [] June 2 [] July 10 [] August 21 [] September 18 [] October 14 [] November 6 [] December 11

Course includes text.

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.m.-5:00 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:

<u>Cancellation Policy</u>: If RECEIVED less than ten BUSINESS DAYS before the course--NO REFUND. If RECEIVED 10 or more business days before the course--full 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.

 Student [] absent [] incomplete [] cancelled on ______ [] verbally [] in writing.

 [] CC Billed [] CC Rejected [] EW attached [] EW billed [] Invoiced [] Training Fund billed

 DATE RECEIVED
 (Form saved 12/12/13, printed 12/12/13)

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

 Name (Please print clearly.)

 E-mail address (This is our default written communication.)

 Address

 Address

 Day

 phone

 Eve

 phone

 Eve

 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

PAYMENTS: Tuition \$57.00 TOTAL: \$_____

CHECK OR MONEY ORDER payable to Robert Wood Johnson University Hospital #______\$____

CREDIT CARD	Circle one:	AmericanExpres	s MasterCard	Visa	Discover
Cardholder's	[] Same as above				
Name					
Cardholder's	[] Same as	above			
Address					
Card					
Number					
Expiration			CVV or		
Date			Security code		
Please read and sign below this statement: I agree to pay the total amount noted above per					

the card issuer agreement.

Cardholder Signature_