



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

Heartsaver First Aid--2014

Date:
 Thursday, May 1, 2014
 Thursday, August 7, 2014

Course includes text. Extra copies are available for purchase.

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: _____

Cancellation Policy: 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	_____		

Day phone	_____	Cell phone	_____
Eve phone	_____	EMS 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 Additional: ExtraText \$9.00 TOTAL: \$ _____
CHECK OR MONEY ORDER payable to Robert Wood Johnson University Hospital # _____ \$ _____

CREDIT CARD	Circle one: AmericanExpress MasterCard Visa Discover		
Cardholder's Name	<input type="checkbox"/> Same as above		
Cardholder's Address	<input type="checkbox"/> Same as above		
Card Number	_____		
Expiration Date	_____	CVV or 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 _____