ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL

Mobile Health Service -- EMS Education Course Application

EMS Education, 1 RWJ Place, Box 2601, New Brunswick, NJ 08903-2601
Office 732-937-8686 | Fax 732-418-8199 | www.rwjuh-ems.org

Request for Replacement Card/Certificate

Please do your best and provide as much of the information below as possible so we can research your course completion documentation.

Course: [ ] ATT [ ] ACLS Provider [ ] ACLS-EP Provider
[ ] BLS for Healthcare Providers [ ] BLS Instructor
[ ] EMT-P Refresher Program [ ] Epi Auto-Injector Inservice
[ ] GEMS—Advanced [ ] GEMS—Basic
[ ] Heartsaver CPR AED [ ] Heartsaver First Aid
[ ] PALS Provider [ ] PEPP—Advanced [ ] PEPP—Basic
[ ] PEARS Provider [ ] PHTLS—Combined Provider

Course Date(s):_____

Location:_____

Optional selections:
[ ] Photocopy, if available ($5.00) [ ] Replacement card/certificate ($10.00)

Required attachments:
[ ] Payment or credit card info

Request acknowledgement by: [ ] E-mail or [ ] Telephone

Replacement Card/Certificate 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:_____

SIGN HERE ► _____

Office Use Only: Acknowledged [ ] in person by [ ] phone [ ] e-mail.
Credential [ ] located [ ] not found. Produced [ ] copy/scan [ ] duplicate on _____.
[ ] CC Billed [ ] CC Rejected [ ] Invoiced [ ] Training Fund billed
DATE RECEIVED (Form saved 8/27/13, printed 8/27/13)

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: [ ] $5.00 copy [ ] $10.00 replacement TOTAL: $_____
CHECK OR MONEY ORDER payable to Robert Wood Johnson University Hospital
#_____ $_____

CREDIT CARD	Circle one: AmericanExpress MasterCard Visa Discover		
Cardholder's Name	[ ] Same as above		
Cardholder's Address	[ ] 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_____