

## PALS 2012

### Pediatric Advanced Life Support

#### Two Day Provider (PAL002) 9:00 am – 5:00 pm

Designed for the new and expired Healthcare Provider

February 7-8	August 14-15
April 23-24	October 15-16
June 6-7	December 6-7

#### One Day Renewal Provider (PAL114) 9:00 am – 5:00 pm

Designed for the renewing provider; MUST possess current AHA PALS Card.

Jan 18	Apr 27	July 26	Oct 26
Feb 23	May 18	Aug 21	Nov 16
Mar 22	June 27	Sept 18	Dec 19

#### Health First Associate Fees:

Provider \$175.00    Renewal \$150.00

#### Cost

#### Public Fees:

Provider \$200.00    Renewal \$175.00

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

#### Course Pre-Requisites

Students are strongly encouraged to prepare in advance of course date. A pre-course, self-assessment is available in the PALS Course Guide/Provider Manual, which is included in course cost.

#### 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](mailto: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

	<u>Provider</u>	<u>Renewal</u>
FL Board of Nursing, #NCE 2046	10 hrs	0 hrs
Bureau of EMS	14 hrs	7 hrs
HRMC Category I CME credit	8 hrs	4 hrs



# 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.	

<b>Cost Center Transfer:</b> (not available for CPR or ACLS)  Manager Signature: _____ Cost Center #: _____ - _____ - _____	<b>Send form and payment to Barbara Couch:</b> Mailing Address: Health First Training Center 3470 N. Harbor City Blvd. Melbourne, FL 32935 E-mail address: <a href="mailto:barbara.couch@health-first.org">barbara.couch@health-first.org</a> 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

Office Use Only:  
 Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

GL Account #050 600001 6405 52 - Training Center