Please make checks payable to: Lowcountry Regional EMS
Payment: Check☐ Cash☐ Bill☐ CC☐ Money Order☐

Lowcountry Regional EMS Council CTC

Phone: (843) 529-0977 Fax: (843) 529-0460
Mail Rosters & Processing Fees To:
237Oakland Drive
Walterboro, SC 29488
E-Mail: scable@lowcountryems.com

INCOMPLETE ROSTERS WILL BE RETURNED

Bill to Name: _____

Address: _____

City/State/Zip: _____

CC#: _____

EXP: _____ **CVZ#** _____ **Zip Code**

TYPE OF COURSE: *(Check only one per roster. New and Renew for same course is acceptable.*

- ☐ BLS Healthcare Provider ($7.00)
- ☐ HS CPR AED (Check all that apply) ($21.00)
  - ☐ Child CPR AED
  - ☐ Infant CPR
  - ☐ Written Test (Optional)
- ☐ Heartsaver 1st Aid ($21.00)
  - ☐ Written Test (Optional)
- ☐ **K-12** HS FA/CPR/AED ($7.00)
  (Faculty, Staff & Students - **Only)**
- ☐ HS 1st Aid, CPR, AED (Check all that apply) ($21.00)
  - ☐ Child CPR AED
  - ☐ Infant CPR
  - ☐ Written Test (Optional)
- ☐ HS Pediatric 1st Aid (Check all that apply) ($21.00)
  - ☐ Child / Infant CPR AED
  - ☐ Adult CPR / AED
  - ☐ Written Test
  - ☐ Family & Friends R/C
- ☐ ACLS Provider ($9.00)
- ☐ PALS Provider ($9.00)
- ☐ PEARS Provider ($9.00)
- ☐ BLS Instructor ($11.00)
- ☐ Heartsaver Instructor ($11.00)
- ☐ ACLS Instructor ($11.00)
- ☐ PALS Instructor ($11.00)

Course Date: _____ Course Hours: _____ Student Manikin Ratio: _____ Course Location: _____
Number of **New** students: _____ Number of **Renewing** students: _____ **Test version used:** _____ **Mannequins Clean/Decontaminated:** _____

****

Instructor Information: *(Please print all unless otherwise instructed) *If required*

Instructor's Printed Name: _____ **Instructor's Signature:** _____
***Affiliate Faculty:** _____ ***Affiliate Faculty Signature:** _____

My signature attests that the course listed was taught in accordance with the policies and procedures set forth by the American Heart Association and Lowcountry Regional EMS CTC.

Home Address: _____ Home #: _____
_____ Work #: _____
_____ Cellular#: _____
E-Mail address: _____
Comments: _____
_____

Mail Cards To:
_____
_____
_____
_____
_____

Assisting Instructors:

Name of Instructor	Assisting Instructor Signature	Home CTC	Renewal Date	Monitored
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

(Additional Instructors should be listed on a separate sheet and attached to this document)

Revised 11/15

Lowcountry Regional EMS Council Roster
PLEASE PRINT (Illegible Names will Not be processed)

	New or renew	**FIRST NAME**	**MI**	**LAST NAME**	Address	Phone #	Post-Test	Skills verified
EX	**R**	**John**	**R.**	**Doe**	**123 Any Street, City, State, ZIP** **email: *scable@email.com***	**843-555-1212**	**100**	**X**
1)					email:			
2)					email:			
3)					email:			
4)					email:			
5)					email:			
6)					email:			
7)					email:			
8)					email:			
9)					email:			
10)					email:			
11)					email:			
12)					email:			
13)					email:			
14)					email:			
15)					email:			
16)					email:			