American Heart Association New Instructor Card Request

Authorized Provider
of CPR and ECC Courses

Course Type (check one): ☐ **BLS** ☐ **ACLS** ☐ **PALS**

Card Type (check one): ☐ **Instructor** ☐ **TC Faculty**

Name: ____

Street Address: ____

City: ____________________ **State:** __________ **Zip:** ______________

Phone: ______________________ **Email:**______________________

Date Monitored by TC or Regional Faculty: ______________________________

(Include copy of Monitoring form)

Date & Total Hours of Instructor Course:

Start Date: ______________ **End Date:** ______________ **Total Hours:** ________

Date Provider card Issued: ____________________ **(Include copy of current provider card)**

☐ **Mail card to the above address**

☐ **I will pick up my card**

I certify the above information is correct and I wish to obtain Instructor status.

______________________________________ ____________________

Signature **Date**