

To all KCC Training Center Aligned Instructors,

Per AHA guidelines, the information below **must** be completed on your roster for cards to be issued for your course. All paperwork should be emailed to aha@kellogg.edu.

Please verify and initial each item as needed below:

<i>Item</i>	<i>Initial</i>
Correct course has been selected	
Instructor/course information has been completed.	
Course meets a 6:1 student/instructor ratio	
<ul style="list-style-type: none"> All assisting instructor information is provided, ensuring a 6:1 student/instructor ratio 	
Form is signed and dated by lead instructor (typing a signature in the PDF is acceptable)	
Student names and emails are provided. Phone numbers are optional	
Course is marked complete for all students	
<ul style="list-style-type: none"> If needed, remediation date provided 	
<ul style="list-style-type: none"> All remediation paperwork included 	
<ul style="list-style-type: none"> PSA Score included for ACLS and PALS courses 	
Evaluations are included for all students	
<ul style="list-style-type: none"> All evaluations have been reviewed and initialed by all instructors 	

I verify the above information is accurate and truthful and that it may be confirmed. This course was taught in accordance with AHA guidelines.

_____ *Instructor Signature* _____ *Date*

FOR OFFICE USE ONLY	
I have reviewed all course paperwork and verify the information provided by the instructor to be true and correct.	
_____ <i>Training Center Staff Signature</i>	_____ <i>Date</i>
<i>Invoice Number:</i> <input style="width: 100px;" type="text"/>	<i>Course:</i> <input style="width: 100px;" type="text"/>

Pediatric Advanced Life Support Course Roster

Emergency Cardiovascular Care Programs



Course Information

- PALS Course
- PALS Update Course
- PALS Traditional Course
- HeartCode® PALS
- PALS Instructor Course

Lead Instructor _____
 Lead Instructor ID# _____
 Card Expiration Date _____
 Training Center _____
 Training Center ID# _____
 Training Site Name (if applicable) _____
 Address _____
 City, State ZIP _____
 Course Location _____

Course Start Date/Time _____	Course End Date/Time _____	Total Hours of Instruction _____
No. of Cards Issued _____	Student-Manikin Ratio _____	Issue Date of Cards _____

Assisting Instructors

<i>Name and Instructor ID#</i>	<i>Card Exp. Date</i>	<i>Name and Instructor ID#</i>	<i>Card Exp. Date</i>
1.		5.	
2.		6.	
3.		7.	
4.		8.	

I verify that this information is accurate and truthful and that it may be confirmed. This course was taught in accordance with AHA guidelines.

 Signature of Lead Instructor

 Date

Course Participants



Date _____ Course _____ Lead Instructor _____ Lead Instr. ID# _____

<i>Name and Email</i> Please PRINT as you wish your name to appear on your card. Please print email address legibly.	<i>Mailing Address/Telephone</i>	<i>PSA Score</i>	<i>Complete/ Incomplete</i>	<i>Remediation/ Date Completed (if applicable)</i>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				