

PARTICIPANT LIST

*For Each Class Completed, This Participant List and the Course Roster (Reverse Side)
MUST Be Returned Along With **Problem** Course Evaluations to Health Counseling TC within 14 Days*

Please **Print** Your Name **Clearly** As You Wish It To Appear On Your Card
If Name Is Not Legible, A Fee Will Be Charged For A Replacement Card

Use Additional Sheets As Needed

First Name	M	Last Name	Address	Telephone (With Area Code)	Exam Score (Optional)	Was Course Completed ¹
1.						Y N
2.						Y N
3.						Y N
4.						Y N
5.						Y N
6.						Y N
7.						Y N
8.						Y N
9.						Y N
10.						Y N

¹ If course was not completed, please make note as to why.

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: _____

Course Completion Date: _____

Send This Form and Problem Evaluations To: Health Counseling Services 615 First Avenue NE, Suite 310 Mpls, MN 55413