

COURSE ROSTER

Health Counseling Training Center Revised 6-08

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

1. COURSE COMPLETION DATE: _____
2. TOTAL HOURS OF INSTRUCTION: _____
3. PLEASE CHECK WHAT TYPE OF COURSE YOU INSTRUCTED AND ANY ADDITIONAL MODULES:
 Healthcare Provider (*Non-Modular, Credentialed*) Initial *or* Renewal *or* Skills
 Heartsaver CPR (*Adult/Child CPR w/ Choking, Modular, Credentialed*) Infant CPR w/ Choking
 Adult/Child CPR w/ Mask Infant CPR w/ Mask
 Heartsaver First Aid (*Adult First Aid, Modular, Credentialed*) Environmental Emergencies Adult/Child AED
 Infant CPR w/ Mask Adult/Child CPR w/ Mask
 Heartsaver Pediatric First Aid (*Pediatric First Aid, Asthma Care, Modular, Credentialed*) Pediatric First Aid Topics
 Adult/Child AED Infant CPR w/ Mask Adult/Child CPR w/ Mask
 Heartsaver AED (*Adult/Child CPR w/ Mask & Choking, Adult/Child AED, Modular, Credentialed*) Infant CPR w/ Mask & Choking
 Heartsaver CPR in Schools (*Adult/Child CPR w/ Choking, Modular, Elective Credentialed*) Adult/Child AED
 Infant CPR w/ Choking Adult/Child CPR w/ Mask Infant CPR w/ Mask
 Family & Friends CPR (*Adult/Child CPR w/ Choking, Modular, Non-credentialed*) Infant CPR w/ Choking
 Family & Friends First Aid for Children (*Child First Aid & Environmental Emergencies, Modular, Non-credentialed*)
4. NUMBER OF STUDENTS WHO WILL BE ISSUED A CARD: _____
If a student is listed on the participant list but does not complete the course or get issued a card, please make note of the reason why in the "Comments" section of this form or on an additional page. Documentation of the remediation and evaluation steps taken to educate this student should be included as to why the student was unable to complete the course.
5. TRAINING SITE NAME OR LOCATION: _____
6. LEAD INSTRUCTOR: _____
7. ASSISTING INSTRUCTORS:
1. _____ 3. _____
2. _____ 4. _____
8. INSTRUCTOR / STUDENT / MANNEQUIN (RATIO): _____ / _____ / _____
9. WHO DECONTAMINATED THE MANIKINS: _____
10. COMMENTS (Use additional pages if necessary): _____

OFFICE USE ONLY

Date Entered: _____

Date Cards Mailed: _____

PARTICIPANT LIST

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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