COURSE ROSTER

Health Counseling Training Center Revised 05-18

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:

☐ **Basic Life Support** ☐ Instructor Led *or* ☐ Blended Learning

☐ **Basic Life Support - Renewal**

☐ **Heartsaver First Aid CPR/AED** *(Adult CPR w/ mask, AED, Adult choking)* ☐ Instructor Led *or* ☐ Blended Learning
☐ Child CPR/AED ☐ Infant CPR ☐ Written Test

☐ **Heartsaver First Aid** *(Adult First Aid)* ☐ Instructor Led *or* ☐ Blended Learning
☐ Written Test

☐ **Heartsaver CPR/AED** *(Adult CPR w/ mask, AED, Adult choking)* ☐ Instructor Led *or* ☐ Blended Learning
☐ Child CPR/AED ☐ Infant CPR ☐ Written Test

☐ **Heartsaver Pediatric First Aid CPR/AED** *(First aid basics, Child/Infant CPR/AED)* ☐ Instructor Led *or* ☐ Blended Learning
☐ Adult CPR AED ☐ Written Test ☐ Asthma Care Video

☐ **Heartsaver for K-12 Schools** *(Adult CPR w/ mask, AED, Adult choking)* ☐ Child CPR AED
☐ Infant CPR ☐ First Aid ☐ Written test

☐ **Family & Friends CPR** *(Adult hands only CPR/AED/Choking, Child CPR/ AED/Choking, Infant CPR/Choking, 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: _____ INSTRUCTOR ID#: _____

7. ASSISTING INSTRUCTORS:

1. _____ID#_____ 3. _____ID#_____

2. _____ID#_____ 4. _____ID#_____

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: _____

Revised 05/2018

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	Email Address (E-Cards)	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 7851 Metro Parkway, Suite 250, Bloomington, MN 55425

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