School of Medicine
Office of Curricular Affairs
Advanced Cardiac Life Support (ACLS)
Recertification Registration Form

Please complete the following, in full. Please Print Clearly.

Last Name: __________________ First Name: __________________
Middle Name/Initial: __________________
Address: ___________________________________________________
City: _______________________ State: ______ Zip: __________
Phone (w): _________________ (h): ________________________
Pager/Cell: _________________ email: ______________________
Occupation: _________________ Employer: ___________________
SLU Department (if applicable): ______________________________
☐ Attending ☐ Fellow ☐ Resident – Year ________________
Date of expiration of previous ACLS certification: ______
Payment ($220.00):

☐ Cash ☐ Check ☐ GME ☐ IDO (SLU depts. only)

I understand that there is a significant expense associated with the provision and delivery of this course. I guarantee with my signature (below) that I will attend the course as scheduled. If you are unable to make your scheduled test time, you MUST provide a minimum of 48 hours notice. Without 48 hours notice, the $220.00 course fee is NON-REFUNDABLE (NO EXCEPTIONS).

Signature: _________________________ Date: ________________

Please submit this registration form (via interoffice mail or fax) with a copy of your ACLS card to:

Wesley Burch
School of Medicine
Office of Curricular Affairs
LRC—Room 001
Fax: 314-977-8088
Phone: 314-977-8445

FOR OFFICE USE ONLY

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<td>Date scheduled:</td>
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<td>Date Completed:</td>
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<td>ACLS Card rec’d/date:</td>
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