ACLS Recertification Course

offered by

MedicEd.com

Registration Form

By submitting the following information, I authorize MedicEd.com to bill me $170 *(payment method selected below)* for ACLS Recertification Provider Course on ______________________________
enter course date to be registered for

To register, please fill out the following information and mail or fax with payment information to MedicEd.com, Inc. at:

MedicEd.com
46 Pilgrim Road
Springfield, MA 01118

(413) 781-1173 office
(877) 781-6055 fax
Rich@mediced.com

Attendee Contact Information: (please print)

Last Name:______________________________ First Name:______________________

EMT #:_________________________ State:_____ Phone Number: (____) ____-________

Expiration date on current AHA or ARC BLS CPR Card: ______________________________

E-Mail Address:____

Mailing Address:

Address:____

City:__________________________________ State:______ Zip:____________

Billing Address **(if different from mailing and REQUIRED if using a PO as payment):**

Address:____

City:__________________________________ State:______ Zip:____________

Attn:__________________________________

Method of Payment: (payment is due prior to class date)

☐ Check (payable to MedicEd.com) ☐Cash ☐PO If paying by PO, Issued by: ____________________

☐ Credit card (fill out following information) PO number: ____________________

Cardholder name (exactly as it appears on card) ______________________________

Card Type: ☐MC ☐Visa ☐AMEX

Credit Card Number:______________________________ Exp Date:__________

Security Code:__________ (3 digit on back of card for MC/Visa, 4 digit on front for AMEX)

Credit Cardholder Billing Information:

Address:____

City:__________________________________ State:______ Zip:____________

By signing below, I authorize MedicEd.com to charge my credit card in the amount of $170.

Authorizing Signature:__________________________ Date:________________

Registration is not guaranteed until receipt of this signed form and payment arrangements are made with MedicEd.com. Attendance for the entire course is required to complete the requirements. By signing this form, I state that I understand and agree to these terms.

Attendee Signature:______________________________ **Date:**______________