Clarinda Regional Health Center

AHA CLASS REQUEST FORM

REVIEWED 01/24

Date:_____ Business Name: _____

Address:_____

CONTACT INFORMATION

Business/Group Contact Person:_____

Contact Phone Number:_____ Contact E-mail:_____

CLASS INFORMATION

Please check which class(es) you would like to have:

- ☐ Basic Life Support (BLS) for Healthcare Providers (preferred for healthcare workers)
- ☐ Heartsaver CPR AED (Adult/Child/Infant)
- ☐ Heartsaver First Aid (Adult/Child)
- ☐ Heartsaver First Aid CPR AED (select one below)
  - ☐ Adult/Child/Infant
  - ☐ Adult/Child
  - ☐ Pediatric Only

Preferred location of training: ☐ CRHC

☐ Business location (specify):_____

Number of attendees:_____ Number of classes requested (max 15 students per class):_____

Class Type: ☐ In person class ☐ Skills exams only

Please list 3 possible dates & times for training:

_____/_____/_____ @ _____

_____/_____/_____ @ _____

_____/_____/_____ @ _____

Full classes are estimated at 3-4 hours in length

Skills exams are estimated at 15-20 minutes
Max 2 students/session

*All requests must be received at least 2 weeks prior to class

*AV equipment is needed for the class. Ability to connect computer to TV or projector is recommended

Please return completed form to Jenny Wagoner at jwagoner@clarindahealth.com