



American Heart Association Emergency Cardiovascular Care Program  
**ADVANCED LIFE SUPPORT COURSE ROSTER**

Please Print Clearly

**REQUIRED—In & out times for student participation**

NAME	Title	Email Address (Required for card)	Dept	BLS Exp	Skills Sheet	Test Score	Comp (C) Incomp (I)	Remed Date	MNA CEUs	Times	
										In	Out
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											

<b>Advanced Life Support</b> <input type="checkbox"/> ACLS Skills Check <input type="checkbox"/> ACLS Provider <input type="checkbox"/> ACLS Renewal <input type="checkbox"/> ACLS Experienced Provider	<b>Pediatric Life Support</b> <input type="checkbox"/> PALS Skills Check <input type="checkbox"/> PALS Provider <input type="checkbox"/> PALS Renewal <input type="checkbox"/> PEARS Provider	<b>ECG &amp; Pharmacology</b> <input type="checkbox"/> ECG/Pharmacology <input type="checkbox"/> ECG <input type="checkbox"/> Pharmacology	<b>Airway Management</b> <input type="checkbox"/> BVM & Adjuncts <input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Esophageal-Tracheal Combitube <input type="checkbox"/> Laryngeal Mask Airway (LMA) <input type="checkbox"/> Impedance Threshold Device (ITD)	<b>Instructor</b> <input type="checkbox"/> ACLS <input type="checkbox"/> ACLS EP <input type="checkbox"/> PALS
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Send all completed rosters to: Billings Clinic Training Center  
 2800 Tenth Avenue North  
 PO Box 3700  
 Billings, MT 59107-7000

TC: Billings Clinic  
 Site: \_\_\_\_\_  
 Begin Date: \_\_\_\_\_  
 Number of Students: \_\_\_\_\_  
 End Date: \_\_\_\_\_  
 Number Completed: \_\_\_\_\_

**Lead Instructor**

Remediated: \_\_\_Yes \_\_\_No  
 Appropriate Ratio: \_\_\_Yes \_\_\_No

**Email Address: (Required)**

	Name	Instructor ID No.	Inst. Expiration Date	Time In	Time Out	Total Hours
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

**Assisting Instructors/Specialty Faculty must attach a copy of their instructor card if aligned with Training Center other than the Billings Clinic.**

Manikins were cleaned according to TC Manikin Cleaning Policy. (Initials)   
 No. Adult:  No. Child:  No. Infant:

I verify this information is accurate and truthful, and that it can be verified. This course was taught in accordance with the current guidelines of the American Heart Association.

\_\_\_\_\_  
 Signature of Course Director Date