



American Heart Association New Instructor Card Request

Authorized Provider
of CPR and ECC Courses



Course Type (check one): BLS ACLS PALS

Card Type (check one): Instructor TC Faculty

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date Monitored by TC or Regional Faculty: _____
(Include copy of Monitoring form)

Date & Total Hours of Instructor Course:

Start Date: _____ End Date: _____ Total Hours: _____

Date Provider card Issued: _____ (Include copy of current provider card)

Mail card to the above address

I will pick up my card

I certify the above information is correct and I wish to obtain Instructor status.

Signature _____

Date _____