



REGISTRATION FORM

Please **PRINT LEGIBLY** for your certification card to be correct. Please attach payment and return form in person or by mail to Sandy Compton at SIUE School of Nursing, Campus Box 1066, Edwardsville, IL 62026. Make checks payable to SIUE SON. All email correspondence should be sent to mberend@siue.edu.

Please fill in your name as you want it to read on your card.

DATE: _____ **DAY:** _____ **TIME OF CLASS:** _____

TYPE OF CLASS: BLS for HCP

INSTRUCTOR(S) NAME: Melisa Berendson

NAME: _____ **PHONE:** _____

PROFESSION: _____

REASON FOR TAKING CLASS: _____

HOME ADDRESS: _____

CITY: _____ **ST:** _____ **ZIP:** _____

SCHOOL ADDRESS: _____

CITY: _____ **ST:** _____ **ZIP:** _____

EMAIL: _____

Test version: **A**

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