

AFFILIATION AGREEMENT

Training Concepts, Inc.
AHA Training Center

Date _____

I designate Training Concepts, Inc.; an AHA designated Training Center, as my primary Training Center (TC). By doing this, I agree to abide by the policies and guidelines established by Training Concepts, Inc. I understand it is my responsibility to provide my teaching rosters and student evaluations to Training Concepts and copies of rosters when I am assisting faculty for another TC. If I attend educator training at another TC, I will provide copies of MY training records along with a copy of the card issued. I will also instruct in accordance with all AHA guidelines.

Signature (An affiliation fee of \$60 is invoiced each year.)

Name _____
(PRINT)

Please complete the following: RN EMT-B Paramedic Teacher Other _____

E-MAIL ADDRESS _____

Cell Phone: _____

Street _____
Mailing Address: (please send any change of address to Training Concepts, Inc. to ensure delivery of instructor info)

City _____ State _____ Zip code _____

Home phone _____ Work phone _____ ext. _____

Employer _____ Work Fax _____

Birth Date (ID purposes) _____

Initial Instructor Training Date _____ 2020 Guidelines Update (Transferring Instrs. Only) _____

Instructor Status

Check appropriate disciplines & provide **copies of current cards** (if applicable).

____ BLS Instructor

____ Heartsaver Instructor

Return form & documentation to:

Training Concepts, Inc.

485 West Armory Drive, Suite A

South Holland, IL 60473

PHONE 708.596.3155 FAX 708.596.1818

Email: OFFICE@LRNCPR.com

Office use only

Date rec'd _____ Copy of cards Facility _____

Fee paid _____ Ck# _____ PO# _____

