

**Silver Cross Hospital
American Heart Association Training Center
BLS, ACLS and PALS Instructor Affiliation Agreement**

I, _____ request to become affiliated with the
Instructor Name
Silver Cross Hospital AHA Training Center as a recognized American
Heart Association Instructor.

I wish to have affiliation as an Instructor for the following AHA
disciplines: BLS ACLS PALS

I agree to be responsible for the safe use of equipment, accuracy of
information taught and adherence to all AHA and SCH TC policies and
procedures.

I have read and agree to adhere to the PAM and SCH Policy and
Procedure Manual for all courses taught. I agree to sign and submit
the required TC Affiliation paperwork prior to signing this Affiliation
Agreement.

I agree to be responsible for monitoring my Instructor status
requirements and ensuring I am monitored at a Provider Course prior
to my expiration date. I agree to strengthen and support the Chain of
Survival and Mission of the AHA in my Community.

As an Affiliated Instructor, I agree to submit the following:
Copy of BLS Healthcare Provider card and relevant discipline
Instructor Card
Copy of the AHA Instructor Essentials Certificate for each
discipline

INSTRUCTOR HISTORICAL DATA FORM

AFFILIATION AGREEMENT

DEMOGRAPHIC SHEET COMPLETED

Affiliation Fee for all Instructors, a onetime payment of \$30.00 payable to Silver Cross EMS Dept.

Recertification courses are usually held in June and the fee is \$20.00 every two years

This agreement can be terminated by either party at any time upon 30 days written Notification.

<hr/>		<hr/>	
Signature of Instructor	Date	Signature of TC Coordinator	Date
Date			
<hr/>		<hr/>	

Print Instructor Name

Print TC Coordinator Name

The information required for Affiliation will be sent to:

Mary Iverson TC Clerk

Silver Cross Hospital EMS Dept.

1900 Silver Cross Blvd

New Lenox, Illinois 60451

Silver Cross Hospital
Community Training Center

INSTRUCTOR HISTORICAL DATA SHEET

Please Print Neatly

INSTRUCTOR NAME: _____ **DATE** _____

HOME ADDRESS: _____ **CITY** _____ **ZIP** _____

BUSINESS ADDRESS: _____ **CITY** _____ **ZIP** _____

HOME PHONE: () _____ **BUS. PHONE** () _____

Instructor Status: (Circle One)

BCLS: **I** **IT** **AF**

Initial Instructor Training Date: _____
Course Completed at: _____

Expiration Date: _____
Date of Last Renewal: _____

ACLS **I** **CD** **AF**

Initial Instructor Training Date: _____
Course Completed at: _____

Expiration Date: _____
Date of Last Renewal/Monitored Course: _____

PALS **I** **CD** **AF**

Initial Instructor Training Date: _____
Course Completed at: _____

Expiration Date: _____
Date of Last Renewal/Monitored Course: _____

APPROXIMATE NUMBER OF CLASSES TAUGHT EACH YEAR: _____

BCLS: **Heartsaver** _____ **Pediatric** _____ **Healthcare Professional** _____

Instructor _____ **Instructor-Trainer** _____

ACLS: **Provider** _____ **Re-Recognition** _____ **Instructor** _____

PALS: **Provider** _____ **Re-Recognition** _____ **Instructor** _____

Do you provide courses outside your current employment? _____ YES _____ NO

Do you teach for financial gain? _____ YES _____ NO

Do you teach solely on a volunteer basis _____ YES _____ NO

Which of the following materials or equipment will you be requesting rental/purchase most often?

Texts:

BCLS Pediatric _____ BCLS Heartsaver _____ Healthcare Proff. _____

BCLS Instructor _____ BCLS Instructor-Trainer _____

ACLS Provider _____ PALS Provider _____

Manikins:

Adult Manikin _____ Baby Manikin _____

Intubation Manikin _____ Lifepak 5 and Simulator _____

Videos:

Basic Life Support _____ If no, what are you using? _____

Participation Cards:

BCLS Pediatric _____ BCLS Heartsaver _____ Healthcare Proff. _____

BCLS Instructor _____ BCLS Instructor-Trainer _____

ACLS Provider _____ PALS Provider _____

Instructor Signature

Date