

Guidelines

2025

Lead (Directing) Instructor's Name: _____ ID No. (initials + last 4 numbers of SSN): _____
(Print)

Home Address (if changed since last class): _____

Telephone: _____ Email Address: _____

Location of class: _____ TOTAL Number of class participants: _____

Type of course: ☐ BLS Provider ☐ HeartSaver CPR ☐ Heartsaver First Aid CPR AED ☐ First Aid Only
(Check one)

☐ Pediatric Heartsaver First Aid CPR AED ☐ CPR Family and Friends ☐ K-12

Level of course: ☐ ACLS Provider ☐ Provider ☐ Renewal ☐ PALS Provider ☐ Provider ☐ Renewal

(Check one)

(Print) Names of Assisting Instructors	ID Number (initials and last 4 numbers of SSN)	Address (if changed since last report)	Member of innovative solutions community training center? Yes/No (if not, send a copy of this report to your CTC)

The above Instructors have demonstrated the knowledge and skills of a current BCLS, ACLS, or PALS Provider and Instructor:

Date Course Completed

Signature of Lead Instructor

***BCLS/ACLS/PALS Instructor Reporting Form - **Please maintain a copy of this record in your files for at least two years.**