



2023 AHA Materials Order Form

Name: _____ Date: _____
 Organization: _____ Phone: _____
 Address: _____ City: _____ ST: _____ Zip: _____
 Lead Instructor: _____ Location: _____
 E-mail Address: _____ Alignment Fee \$ _____ Site Fee \$ _____

Please submit course roster for the E-cards that you are ordering. After all required paperwork & payment are received, E-cards will be issued. EMT Associates TCC reserves the right to refuse issuance of any E-cards. ACLS, ACLS-EP, PALS and Instructor Courses must be pre-approved by Mary Vaughan. **!!ALL E-CARDS MUST BE PRE-PAID!!**

Type of E-Cards:	Current Price:	# Requested:				Total:
<input type="checkbox"/> BLS HCP Provider	\$8.15/Card	_____	X	\$8.15/Card	=	\$ _____
<input type="checkbox"/> HeartSaver CPR/AED	\$23.75/Card	_____	X	\$23.75/Card	=	\$ _____
<input type="checkbox"/> HeartSaver First Aid	\$23.75/Card	_____	X	\$23.75/Card	=	\$ _____
<input type="checkbox"/> HeartSaver First Aid/CPR/AED	\$23.75/Card	_____	X	\$23.75/Card	=	\$ _____
<input type="checkbox"/> HeartSaver Pediatric First Aid	\$23.75/Card	_____	X	\$23.75/Card	=	\$ _____
<input type="checkbox"/> ACLS	\$17.25/Card	_____	X	\$17.25/Card	=	\$ _____
<input type="checkbox"/> ACLS-EP	\$19.00/Card	_____	X	\$19.00/Card	=	\$ _____
<input type="checkbox"/> PALS	\$17.25/Card	_____	X	\$17.25/Card	=	\$ _____
<input type="checkbox"/> PEARS	\$18.00/Card	_____	X	\$18.00/Card	=	\$ _____
Instructor Cards:	BLS	ACLS	<input type="checkbox"/> PALS	X	\$30.00	= \$ _____

Please load cards to my AHA Instructor account Please make e-cards for me [**\$20 Fee per page of 10 names**]

E-card Processing Fee: 1-11 Cards \$4.25 12-99 Cards \$8.75 100+ Cards \$12.75 = \$ _____

Replacement Cards:	Heartsaver & All Instructor Cards	X	\$35.00/Card	=	\$ _____
<input type="checkbox"/> BLS	<input type="checkbox"/> ACLS	<input type="checkbox"/> PALS	<input type="checkbox"/> Other _____	X	\$30.00/Card = \$ _____
Course Date: ____/____/____		Location: _____ Instructor: _____			

PAYMENT INFORMATION:

GRAND TOTAL = \$ _____

I wish to pay by:

Check Discover Mastercard Visa American Express

CREDIT CARD # _____ EXP DATE: ____/____ CVS CODE [back of card]: _____

CARDHOLDER NAME or COMPANY TO BE INVOICED: _____

CARDHOLDER or AUTHORIZED PERSONNEL SIGNATURE: _____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____