



## Neonatal Resuscitation Program (NRP)

### With Deb Castile

(541) 510-2576

**Classroom Address:**

**Gateway Office Plaza  
1144 Gateway Loop, Suite 136  
Springfield, OR 97477**

Must complete ALL lessons 1-9 inclusive on the written test prior to skills

The online Exam is found at <http://www2.aap.org/nrp/>

**PLEASE SCHEDULE YOUR SKILLS TESTING WITH DEB (541) 510-2576 PRIOR TO COMPLETING THE ONLINE EXAM**



**Please complete the form and submit to: EMT Associates – 1144 Gateway Lp, St 136, Springfield, OR 97477  
Fax: 541-636-3416 emt.associates@comcast.net**

I HAVE SCHEDULED A TIME AND COMPLETED THE ONLINE PORTION     NPR SKILLS TEST \$150.00

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

*\*E-mail is required for all pre-course information.*

My Scheduled time is: \_\_\_\_\_

Total Payment Enclosed: \_\_\_\_\_

Select Payment Method		
<input type="checkbox"/> Cash	<input type="checkbox"/> Check	<input type="checkbox"/> Card
Select Card Type		
<input type="checkbox"/> Visa	<input type="checkbox"/> Master Card	<input type="checkbox"/> American Express
	<input type="checkbox"/> Diners Club	<input type="checkbox"/> Discover Card
Card #: _____ - _____ - _____		
Expiration Date: ____/____/____ Security Code: _____		
Card Holder's Name: _____		
Card Holder's Signature: _____		