



Pediatric Advanced Life Support (**PALS**) at Doctors Community Hospital

The **PALS** course was developed by the American Heart Association (AHA) to develop proficiency in the **PALS** guidelines. Prior to the class applicants need to practice identifying and interpreting core ECG rhythms and study basic pharmacology and know when to use which drug. The course consists of lectures, skill stations, teaching stations and a final evaluation session. **PALS** provider cards are valid for a two (2) year period.

In order to have a successful experience in **PALS**, review of the material in the *Pediatric Advanced Life Support Provider Manual* (copyright 2010) is necessary. The study packet that is provided includes the current **PALS** algorithms. This is located at www.phsinstitute.com click on study information for class. You must thoroughly review these materials prior to class.

Although each course provides lecture and training sessions, past experiences have illustrated that participants must come well prepared to successfully complete **PALS**. American Heart Association places a great deal of emphasis on Basic Life Support, so it is imperative that you review basic life support as well.

Please note that you will be responsible for your own breakfast, lunch and snacks. You are welcome to bring a bagged lunch or use our cafeteria. **Classes begin promptly at 8:00 am and end by 5:00 pm @ the North Building, 4th Floor, Classroom 415. Please arrive no later than 7:45 am for registration.**

If you have any questions or concerns about the registration process, please do not hesitate to call (301) 552-8072.

Please note the following:

1. You must have a current BLS Healthcare Provider card **attached** to your registration form.
2. If you are taking this class for the first time or if your card is expired, you must take the **PALS Provider Class**.
3. If you do not have a current **PALS** book, you may purchase one. For online book purchase: <http://www.phsinstitute.com/signup.html> or <http://shop.aha.channing-bete.com/onlinestore/search.html?da=A9040>

CANCELLATION / REFUNDS / RESCHEDULING POLICY

Registrations cancelled five days or more prior to the class will be refunded fifty percent or the registration fees can be moved to the next class. No registration cancelled within five days of class will be refunded or rescheduled.

CLASS SIZE POLICY: If a class has less than five (5) registered participants; five (5) calendar days before the class, we may cancel the course. In this case, we will notify students (via email) of rescheduling or refunds.

INCLEMENT WEATHER POLICY: **PALS** will only be cancelled under extreme emergency conditions. A message will be left on voicemail at 301-552-8072 regarding closure or late opening.

****** PLEASE BRING YOUR BOOK AND PRE-COURSE PREPARATION CHECKLIST TO CLASS! ******

**** Cleaning solutions such as bleach and other disinfectants may be used to sanitize manikins.
Please inform your instructor of any allergies. ****



ACLS and PALS REGISTRATION FORM

Please read and complete all items, including pre-course preparation checklist on the next page.

Incomplete applications will not be processed.

Course: ACLS Provider ACLS Renewal PALS Provider PALS Renewal

COURSE DATE: _____ DEPT: _____ EMPLOYEE ID: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

EMPLOYER: _____

***EMAIL: _____

WORK PHONE: _____ HOME PHONE: _____

PLEASE CHECK ONE: EMT-P NP RN MD RT PA OTHER: _____

COURSE FEES

| | DCH Employee | Non-Employee/Physician |
|---------------------|---------------------|-------------------------------|
| <u>ACLS:</u> | | |
| Provider | \$150.00 | \$200.00 |
| Renewal | \$80.00 | \$125.00 |
| <u>PALS</u> | | |
| Provider | \$150.00 | \$200.00 |
| Renewal | \$80.00 | \$125.00 |

Please make checks payable to Terry White- PHS Institute

Mail or deliver this Registration Form to: Anna Godfrey
8118 Good Luck Road- North Building 4th Floor
Education Department
Lanham, Maryland 20706

The American Heart Association strongly promotes knowledge and proficiency in BLS, ACLS, and PALS and has developed instructional materials for this purpose. Use of these materials in an educational course does not represent course sponsorship by the American Heart Association, and any fees charged for such a course do not represent income to the Association.

Applicant Signature: _____

Manager/Director Signature (if DCH employee): _____

Administrator Signature (if DCH employee): _____



ACLS and PALS Provider / Renewal
Pre-Course Checklist

Please complete and return with the COMPLETED registration form to the: **Education Department** *during normal business hours (8:00am –4:00pm)*

Non-DCH Participant, Mail to:
Education Department
Doctors Community Hospital
8118 Good Luck Rd Lanham-Seabrook, MD 20706

Please review all items and sign below:

- I understand that pre-course study correlates with my success in the **ACLS/PALS** Program.
- I have or will obtain a current **ACLS/PALS** book.
- I understand that **ACLS/PALS** are national, standardized programs and that I must pass the three testing stations within AHA time limits stated by the **ACLS/PALS** instructors to pass the course.
- I have included my **payment (cost center for DCH staff) to hold my space** in this class.
- I have read, understood and agree to the Registration/Cancellation/Rescheduling and Refund Policy described in the registration form.
- Cleaning solutions, such as bleach and other disinfectants, maybe used to sanitize manikins. Please inform instructor of any allergies. Doctors Community Hospital is not responsible for any damage that may occur to clothing during the course. Participants are requested to wear comfortable clothing during skills demonstration. Please remove any lip gloss/lipstick prior to breathing demonstration.

Applicant Signature: _____

Today's Date: _____ Phone Number: _____

**DOCTORS COMMUNITY HOSPITAL
CHECK REQUEST**

Payable To: **Terry White**
PHS Institute

Purpose: **ACLS OR PALS** registration for _____
(PLEASE PRINT Employee's Name)

Provider Dates: _____
(Write in the provider dates here)

OR

Renewal Date: _____
(Write in the renewal date here)

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| CRP                    | DEPT                         | SUBCODE | AMOUNT                    |
|------------------------|------------------------------|---------|---------------------------|
| 01.                    | _____                        | .5620   | \$ _____                  |
| <b>Dept. Approver:</b> | <b>Dept Cost Center here</b> |         | <b>Cost of class here</b> |

**SPECIAL HANDLING INSTRUCTIONS**  
**CHECK WILL BE MAILED UNLESS OTHERWISE NOTED**

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**Signatures**

Prepared By: \_\_\_\_\_  
\*\*\*Please do not forward application if all attachments are not completely filled\*\*\*

Dept Approval: \_\_\_\_\_  
\*\*\*Please do not forward application if all attachments are not completely filled\*\*\*

Admin. Approval: \_\_\_\_\_  
\*\*\*Please do not forward application if all attachments are not completely filled\*\*\*

**X ENCLOSE ATTACHMENTS (Registration Forms & Copy of BLS/CPR Card)**