

American Red Cross

Professional Rescuer First Aid and CPR/AED Activity Report

TRAINING SITE INFORMATION	COURSE INFORMATION																																													
Red Cross Unit Where Course Was Taught _____	Start Date: _____ End Date: _____																																													
Facility Name _____	PROGRAM <input type="checkbox"/> CPR/AED for the Professional Rescuer <input type="checkbox"/> Bloodborne Pathogens: PDT <input type="checkbox"/> Emergency Response <input type="checkbox"/> Administering Emergency Oxygen																																													
Facility Address _____ <small>Street Address</small>																																														
_____ <small>City, State, Zip</small>	Course Name: _____																																													
Facility Contact _____	Course Format: <input type="checkbox"/> Full Course <input type="checkbox"/> Review <input type="checkbox"/> Challenge																																													
Facility Phone _____	Total Individuals Enrolled in the Course:																																													
AP Name/ID No. _____	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width:10%;">Components</th> <th style="width:10%;">Emergency Response</th> <th style="width:10%;">CPR/AED for the Professional Rescuer</th> <th style="width:10%;">CPR/AED for Lifeguards</th> <th style="width:10%;">Administering Emergency Oxygen</th> <th style="width:10%;">Bloodborne Pathogens: PDT</th> <th style="width:10%;">Epi-Auto Injector</th> <th style="width:10%;">Asthma Inhaler Training</th> <th style="width:10%;">Other:</th> </tr> </thead> <tbody> <tr><td>Number Enrolled</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Number Passed</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Number Inc./Audit</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Total Hours</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>	Components	Emergency Response	CPR/AED for the Professional Rescuer	CPR/AED for Lifeguards	Administering Emergency Oxygen	Bloodborne Pathogens: PDT	Epi-Auto Injector	Asthma Inhaler Training	Other:	Number Enrolled									Number Passed									Number Inc./Audit									Total Hours								
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AP Address (if different from Facility) _____																																														

TRAINING DELIVERY Full Service Community Authorized Provider

TRAINING AUDIENCE	DEMOGRAPHIC INFORMATION
Check the box that best describes the training audience: <input type="checkbox"/> OCCUPATIONAL/WORKPLACE (Manufacturing, Administrative/Office, Retail Store/Mall, Transportation Center) <input type="checkbox"/> MEDICAL/RESCUE (Hospital, EMS/Fire, Police) <input type="checkbox"/> ACADEMIC (K-12, College, University, Trade school) <input type="checkbox"/> CONSUMER (Youth group, Military, Community group, Religious group, Parks & Recreation/Government)	(optional) Ethnic Origin: <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Did Not Report Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

CERTIFICATES (check one) <input type="checkbox"/> Certificates issued on site <input type="checkbox"/> Instructor will pick up <input type="checkbox"/> Send to Instructor at Instructor's address		<input type="checkbox"/> Send to facility's address Attn: _____ <input type="checkbox"/> Send to AP address Attn: _____	
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INSTRUCTOR INFORMATION	ID No.
Instructor Name _____	
Instructor Address _____ <small>Street Address</small>	
<input type="checkbox"/> Check here if new address or telephone number.	
_____ <small>City, State, Zip</small>	
Instructor Telephone Number () _____	
E-mail _____	
Instructor Signature _____ <small>(not required if Instructor ID is provided)</small>	
Instructor Unit of Authorization _____	
Course taught as <input type="checkbox"/> Red Cross Volunteer <input type="checkbox"/> Red Cross Employee <input type="checkbox"/> Authorized Provider	

CO-INSTRUCTOR INFORMATION	ID No.
Instructor Name _____	
Instructor Address _____ <small>Street Address</small>	
<input type="checkbox"/> Check here if new address or telephone number.	
_____ <small>City, State, Zip</small>	
Instructor Telephone Number () _____	
E-mail _____	
Instructor Signature _____ <small>(not required if Instructor ID is provided)</small>	
Instructor Unit of Authorization _____	
Course taught as <input type="checkbox"/> Red Cross Volunteer <input type="checkbox"/> Red Cross Employee <input type="checkbox"/> Authorized Provider	

COMMENTS

By submitting this form the instructor(s) acknowledges that the course was taught according to American Red Cross standards.

RED CROSS OFFICE USE ONLY						
Total Fees Collected	Red Cross Branch	Date Received	Date Certs Issued	Date Closed in LMS	Person Entering Data	LMS Class ID Number