



Children's National Medical Center Division of Transport Medicine PALS Payment Form

ALL FIELDS MUST BE COMPLETED FOR THIS FORM TO BE PROCESSED

Name: _____
(PLEASE PRINT)

Department: _____

Work email: _____@childrensnational.org

Payment Requested For:

- | | |
|---|--|
| <input type="checkbox"/> PALS Provider Course (\$350) | <input type="checkbox"/> PALS Renewal Course (\$255) |
| <input type="checkbox"/> PALS HeartCode Skills Session + Key (\$285) | <input type="checkbox"/> PALS Textbook (Fee: \$60.00)** |
| <input type="checkbox"/> PALS/PEARS Instructor Course (\$350) | <input type="checkbox"/> PEARs (\$125) <i>Includes textbook to borrow.</i> |
| <input type="checkbox"/> BLS Instructor (\$100) | <input type="checkbox"/> BLS Provider (\$110) <i>Includes textbook to borrow</i> |
| <input type="checkbox"/> ACLS Provider (\$350) <i>Includes textbook to borrow</i> | <input type="checkbox"/> ACLS Renewal (\$255) <i>Includes textbook to borrow</i> |
| <input type="checkbox"/> ACLS HeartCode Skills Session + Key (\$285) | |

**The PALS textbook is included in the cost of the "PALS Provider" and "PALS Renewal" courses.

Students enrolling in any PALS Program course agree to abide by the current Children's National Medical Center PALS Program and Training Center Refund Policy. Cancellations or rescheduling requests will be honored only if received 14 days prior to the first day of the scheduled course. Only one rescheduling request will be honored. All refunds will be subject to an administrative cancellation fee. Students that do not cancel their registration and do not show up to class will not receive a refund and will not be permitted to change their registration. I understand that cancellation or rescheduling of my enrollment in a course within 14 days of the course start date will require me to pay the course tuition fee.

Employee Signature: _____ Date: ____/____/____

MANAGEMENT APPROVAL (REQUIRED FOR ALL APPLICANTS):

THIS REQUEST FOR PAYMENT OF THE REGISTRATION COST IS

☐ APPROVED

☐ DENIED

Manager/Director Name: _____

Manager/Director Signature: _____ Date: ____/____/____

Cost Center paying for this Class: _____

Please send this completed form to: **VClarke@cnmc.org**