



**TRAINING CENTER
ALIGNMENT FORM/INSTRUCTOR APPLICATION**

Name: _____ MD/DO RN EMT-P Other _____

mailing address preference

Home Address: _____ SS#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Work Fax: _____

E-mail address: _____

ECC PROVIDER/INSTRUCTOR HISTORY

Instructor level applying for: Instructor
 Training Center Faculty Staff

Expiration date on current card: _____
(*Copy of front & back of current card must accompany this form*)

Date of last renewal: _____

Name of TC institution renewal received from: _____

CURRENT STATUS

Check all current cards held:

- | | | |
|--|--|---|
| <input type="checkbox"/> BLS Healthcare Provider | <input type="checkbox"/> ACLS Instructor | <input type="checkbox"/> PEARS Provider |
| <input type="checkbox"/> BLS Instructor | <input type="checkbox"/> ACLS Experienced
Provider Instructor | <input type="checkbox"/> Area Task Force |
| <input type="checkbox"/> BLS Instructor Trainer | <input type="checkbox"/> PALS Provider | <input type="checkbox"/> Regional Faculty |
| <input type="checkbox"/> ACLS Provider | <input type="checkbox"/> PALS Instructor | <input type="checkbox"/> Other Status _____ |
| <input type="checkbox"/> ACLS Experienced Provider | | |

Cards other than AHA (*copy of front & back of those cards must accompany this form*):

ADDITIONAL INFORMATION

Previous TC affiliation, if applicable: _____

Have you taught for other training sites or TC's? Yes No (If yes, list below)

Site: _____ City: _____

Contact Person: _____ Phone: _____

Site: _____ City: _____

Contact Person: _____ Phone: _____

Previous teaching experience: _____

SPENCER HOSPITAL TC ALIGNMENT AGREEMENT (Instructor Applicant)

If accepted as an Instructor for the Spencer Hospital TC, I agree to abide by the policies and procedures of the SHTC outlined in the ECC Instructor Guide provided to me by SHTC. I further agree to abide by the guidelines recommended by the American Heart Association as outlined in the instructor manuals appropriate to the course I teach. In signing below, I affirm that the information contained in this application is truthful.

Signature: _____ Date: _____

Please return to: **Spencer Hospital – HRD Department**
Jeff Messerole, TC Coordinator
1200 1st Ave East, Spencer, IA 51301
1-712-264-6517 or 1-712-264-6117
jmesserole@spencerhospital.org

SPENCER HOSPITAL TC ALIGNMENT AGREEMENT (TC Representative)

In accepting the above-named instructor applicant as an instructor for the SHTC, it is acknowledged that the SHTC has responsibilities to the Instructor as outlined in the SHTC and Policy and Procedure Manuals. The SHTC agrees to these responsibilities and hereby accepts the above-named applicant as an approved Instructor for the following ECC programs:

BLS Instructor BLS Training Center Faculty ACLS Instructor PALS Instructor Other _____

This is the SHTC Instructor ID Number that has been assigned to you _____

SHTC Representative Signature: _____ Date: _____