OFFICE USE ONLY
Confirmation given on _____
Via ☐ Post Card Home Phone
Work Phone Message left with_____
Email

Registration Form

Complete and mail to: Jackie Brown Pee Dee AHEC PO Box 100551 Florence, SC 29501-0551
Tel # (843) 777-5348 or Fax # (843) 777-5354

Program Title: Central Venous Access Devices **Program Date** _____
Registration Fee: $50.00

Statement of Responsibility for Competency Assessment

To be signed by a representative of the employing agency

I acknowledge that the applicant meets the eligibility requirements for this course and that the employing agency is responsible for determining the competency of the LPN through clinically supervised return demonstration based on agency-specific policies, procedures, and standing orders.

_____ _____
Signature of Immediate Supervisor **Date**

Participant Name_____ **Title**_____ **Date of Birth**____/___/____

Personal ID _____/_____/_____
Birth month/ day/ last 4 digits of SS#

Gender __**M** __**F** **Race** __ **American Indian or Alaska native** __ **Hispanic or Latin**
__ **Native Hawaiian or Other Pacific Islander**
__ **White** __ **Underrepresented Asian**
__ **Asian (not underrepresented)** __ **Back or African American**

Licensure RN____**LPN**_____ **other (specify)**_____ **Department**_____

Home Phone_____**Work Phone**_____

Home Address _____**Zip** _____

Fax #_____ **E-Mail address**_____

Employer_____ **Employer County**_____

Work Address _____**Zip** _____

*****Confirmation of your registration will be mailed to your home address***