

Instructor: _____

HS BLS

1. I understand that Conway Regional Health System (CRHS) is an approved American Heart Association (AHA) Training Center for the disciplines of HeartSaver (HS) and Basic Life Support (BLS) for the Region of Arkansas.
2. I understand that CRHS Training Center has agreed to process all of my course documents and validate courses in the future.
3. I understand that I must maintain all records for any courses that I teach (course rosters, answer sheets, and skills sheets) for no less than 3 years and relinquish to the Training Center upon request.
4. I understand that as an AHA Instructor I am responsible for the security and proper handling of all AHA cards and exams.
5. I understand that at any time my courses may be reviewed for quality assurance.
6. I understand that when I submit course documents to the Training Center for processing that it must contain payment for such processing unless prior arrangements have been made with the Training Center Coordinator. Without payment the paperwork will be returned to the instructor unprocessed.
7. I agree to only teach and follow the guidelines set forth by the AHA and the Policy and Procedures of CRHS Training Center in all AHA courses.
8. I agree to ensure that I will teach and have available all updated AHA materials, such as instructor manuals, provider manuals, DVDs, Exams, and equipment.
9. I agree to teach the minimum number of courses in order to maintain my instructor status. AHA requires you to teach a total of 4 per 2-year instructor certification.
10. I agree to make NO alterations on any AHA Course Completion card at any time. If an error is made, I understand that I must send that card to the Training Center. CRHS Training Center is responsible for tracking all cards.
11. I agree to update CRHS Training Center of any changes to my instructor status, contact information, and discrepancies with any course I instruct.
12. I agree to attend instructor updates as required periodically by AHA and/or CRHS Training Center.
13. I understand that it is at the discretion of the CRHS Training Center to continue my affiliation and that I can change Training Centers at any time upon written notification to the CRHS Training Center Coordinator.

I have read thoroughly, understand, and agree to the Instructor Agreement along with the Policies and Procedures of Conway Regional Health System Training Center and the American Heart Association Program Administration Manual.

Instructor_____
Date_____
Training Center Coordinator_____
Date