Central MA EMS Corp.
361 Holden Street
Holden, MA 01520

(508) 854-0111
(508) 853-3672 fax
www.cmemsc.org

AHA Training Center ID# MA00690
Sent Roster to:
trainingcenter@cmemsc.org

American Heart Association Emergency Cardiovascular Care Programs
2025 Heartsaver® Course Roster - All Courses

Instructor: Ensure each section of this roster is completed **legibly** and submit original to CMEMSC within **five (5) days** of course completion.

Course Information

☐ **Heartsaver K-12 for Schools**
Optional: ☐Child CPR AED ☐Infant CPR ☐First Aid ☐Exam

☐ **Heartsaver First Aid CPR AED**
Optional: ☐Heartsaver Total ☐Child CPR AED ☐Infant CPR ☐Exam

☐ **Heartsaver CPR AED** only
Optional: ☐Child CPR AED ☐Infant CPR ☐Exam

☐ **Heartsaver First Aid** only Optional: ☐Exam

☐ **Heartsaver Pediatric First Aid CPR AED**
Optional: ☐HS Pediatric Total ☐ Pediatric First Aid ☐ Child/Infant CPR AED
☐ Adult CPR AED ☐Exam ☐ Asthma Care Video

☐ **Blended Learning** (Must complete appropriate modules above and attach online certificate)

Course Location: _____

Street Address: _____

City, State, Zip _____

Start Date _____ End Date: _____

Start Time _____ End Time: _____

Student to Manikin Ration: _____ / _____

Lead Instructor: _____

Status: ☐ BLS ☐ HS Instructor Renewal Date: _____

Assistant Instructor*: _____

Status: ☐ BLS ☐ HS Instructor Renewal Date: _____

Assistant Instructor*: _____

Status: ☐ BLS ☐ HS Instructor Renewal Date: _____

**List Assistant Instructors only for courses with more than 6 students. Attach copy of instructor card for instructors not aligned with CMEMSC.*

I verify that this information is accurate and truthful and that it may be confirmed. This course was taught in accordance with AHA guidelines.

Signature of Lead Instructor: _____ **Date:** _____

☐ Bill Service/Dept: _____ ☐ Email Bill to: _____

☐ Bill Instructor ☐ Billing Address: _____ **Make check payable to:** CMEMSC

CMEMSC Use Only: Date Received_____ Issued eCards to:_____ ☐Instructor ☐Students Directly TCC Approval:_____

CMEMSC Invoice #_____ PO #_____ ☐ PAID _____ Billing Approval:_____

☐ **K-12** ☐ **HS First Aid CPR AED** ☐ **HS CPR AED** ☐ **HS First Aid** ☐ **Pediatric** **Date** _____ **Instructor** _____

Please print all of your information **clearly** to avoid disappointing errors which will cause delays in issuing a valid eCard.

Print **First & Last Name** CLEARLY -do *not* sign	Print **Email** CLEARLY- ***Required*** (will not be shared)	Print **Cell Phone #** *Allows student to claim ecards by SMS Text*	*Instructor Use* ü = Complete X = Incomplete
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Contact information is used for quality assurance purposes only. *08/2025*