

# AFFILIATION AGREEMENT

Training Concepts, Inc.  
AHA Training Center

Date \_\_\_\_\_

I designate Training Concepts, Inc.; an AHA designated Training Center, as my primary Training Center (TC). By doing this, I agree to abide by the policies and guidelines established by Training Concepts, Inc. I understand it is my responsibility to provide my teaching rosters and student evaluations to Training Concepts and copies of rosters of when I am assisting faculty at another TC. If I attend educator training at another TC, I will provide copies of MY training records along with a two-sided copy of the card issued. I will also instruct in accordance with all AHA guidelines.

\_\_\_\_\_  
Signature (An affiliation fee of \$60 is invoiced each year.)

Name \_\_\_\_\_  
(PRINT)

Please complete the following:  RN  EMT-B  Paramedic  Teacher  Other \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home FAX # \_\_\_\_\_

Street \_\_\_\_\_  
Mailing Address: (please send any change of address to Training Concepts, Inc. to ensure delivery of instructor info)

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ ext. \_\_\_\_\_

Employer \_\_\_\_\_ Work Fax \_\_\_\_\_

Birth Date (ID purposes) \_\_\_\_\_

Initial Instructor Training Date \_\_\_\_\_ 2005 Guidelines Update (Transferring Instrs. Only) \_\_\_\_\_

## **Instructor Status**

Check appropriate disciplines & provide **copies of current cards** (if applicable).

\_\_\_ BLS Instructor

\_\_\_ Heartsaver Instructor

\_\_\_ AHA First Aid Instructor; Date of orientation \_\_\_\_\_

## **Return form & documentation to:**

**Training Concepts, Inc.**  
473 East 161<sup>st</sup> Place  
South Holland, IL 60473  
PHONE 708.596.3155 FAX 708.596.1818

Office use only

Date rec'd \_\_\_\_\_ Copy of cards  Facility \_\_\_\_\_

Fee paid \_\_\_\_\_ Ck# \_\_\_\_\_ PO# \_\_\_\_\_

