



LIFESAVING SOCIETY
The Lifeguarding Experts

**Cardiopulmonary Resuscitation
Health Care Provider (CPR-C-HCP)**

Automated External Defibrillation (AED)
(Revised 2006)

Side 1: Please **print** each candidate's name and contact information legibly.

Date of birth

CPR-C-HCP

AED

1	2	3	4	5	6	7	8	Written test	AED		Result	
									1	2		
Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	Name: _____ Address: _____ City: _____ Postal Code: _____ Date of birth: Year: _____ Month: _____ Day: _____	

Check box if there are more candidates on the reverse side of this page. - Satisfactory Performance **F** - Fail Total Pass for Exam Total Fail for Exam
This test sheet is Page _____ of _____ Pages.

Awards information
 Awards issued by affiliate Awards not issued

Payment information
 Exam fees attached Exam fees not attached

Send invoice or receipt to:

Host name (Affiliate) Telephone _____

Street address

City Prov. Postal code

Exam information
Exam date: _____
YY MM DD

Facility name (e.g., name of pool) Telephone _____

This section to be completed by the Advanced First Aid Examiner who examined the CPR-C-HCP candidates or the AED Examiner who examined the AED candidates.
Examiner's name ID# (optional) _____
E-mail address _____

Telephone Signature _____



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**Cardiopulmonary Resuscitation
Health Care Provider (CPR-C-HCP)**

Automated External Defibrillation (AED)
(Revised 2006)

Side 2: Please **print** each candidate's name and contact information legibly.

Date of birth

CPR-C-HCP

AED

7	Name	Year	Month	Day	One-rescuer CPR: adult, child & infant	Two-rescuer CPR: adult, child & infant	Obstructed airway: conscious adult & child	Obstructed airway: conscious infant	Obstructed airway: unconscious adult, child & infant	Use of AED	Rescue breathing	Use of Bag-Valve-Mask (BVM)	Written test	AED knowledge: use and operation	One- and two-rescuer AED	Result
					1	2	3	4	5	6	7	8	1	2		
8	Name	Year	Month	Day												
9	Name	Year	Month	Day												
10	Name	Year	Month	Day												
11	Name	Year	Month	Day												
12	Name	Year	Month	Day												

Check box if there are more candidates on the reverse side of this page. This test sheet is Page _____ of _____ Pages.

- Satisfactory Performance **F** - Fail Total Pass for Exam Total Fail for Exam

Host name (Affiliate) _____ Telephone _____

Please complete Instructor, Awards and Payment information sections on Side 1 of test sheet. Host name, Exam information and Examiner sections must be completed on both sides 1 and 2 of the test sheet.

Exam information

Exam date: _____ Exam is: Original **OR** Recert

Facility name (e.g., name of pool) _____ Telephone _____

This section to be completed by the Advanced First Aid Examiner who examined the CPR-C-HCP candidates or the AED Examiner who examined the AED candidates.

Examiner's name _____ ID# _____

E-mail address _____

Telephone _____ Signature _____