

**OFFICE USE ONLY**

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Via  Post Card

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**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)       Black 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**