HSHS St. John's Hospital SAMIC EMS System

Program Attendance Record

Program Title: _____

Date: _____ Time: _____ Program Length: _____

Program Location: _____ Site Code: _____

NAME ***(PRINT)***	***SIGNATURE***	***ADDRESS***	***LEVEL OR TITLE***	***AGENCY***	***LICENSE #***

This document is to be completed at all educational seminars approved by the SAMIC EMS System and mailed back or faxed to the EMS office at 757-6047. All personnel in attendance shall be required to provide the above information requested within each field to receive continuing educational credits.