EAST JAMAICA CONFERENCE OF SEVENTH-DAY ADVENTISTS
HEALTH MINISTRIES DEPARTMENT (876) 619-2855-3
FIRST AID/CPR APPLICATION FORM

INSTRUCTIONS: Please provide all information requested. If payment is not in full, this must be completed before day two of the training. A receipt must be submitted along with your application.

A. APPLICANT'S PERSONAL INFORMATION:

i) NAME: _____ _____ _____
Last First Middle

ii) ADDRESS: _____

_____

iii) Email: _____ iv) Telephone: (876) _____

v) Age Group Tick (√): 15–25 ☐ 26-35 ☐ 36 – 50 ☐ Over 50 years ☐

vi) Marital Status Tick (√) Applicable Box: Single ☐ Married ☐ Other ☐

vii) Gender Tick (√) Applicable Box: Male ☐ Female ☐ viii) Occupation: _____

B. **CHURCH INFORMATION**:

ix) _____ _____
a) Name of Church b) Name of Pastor

x) Are you a Seventh-day Adventist? ☐ Yes ☐ No xi) If yes, for how long? _____ years/months

xii) Main Position at church: _____

xiii) State how you will use the information from this training to help others. (Be specific in your answer.)

_____

_____

xiv) Do you know of any known condition that would prevent you from completing this certificate training programme? If yes, please explain: _____

_____

xv) Applicant's Signature: _____ xvi) Date: _____

FOR OFFICIAL USE ONLY

Registration Fee: $7,500 & lunch: $1,200 Registration #: _____ Date: _____

Amount Paid: Cash ☐ Cheque/card ☐ # _____ Receipt #: _____

Balance Due $_____ Final Payment Date: _____

Approved: ☐ Disapproved: ☐ Date: _____

Approved by: _____ Signature: _____ Date: _____