Date____________________

CPR TRAINING UNIT APPLICATION

Name of organization ____

Address ____

City ___________________________ State ________________ Zip ___________________

Contact name ____

Title ________________________________ Telephone (_______)_______________________

ORGANIZATION BACKGROUND Year founded ____________________

How supported ____

____

Purpose of organization ____

____

____

Number of people to be trained__________________ Number of similar units available__________________

Brief description of program ____

____

____

CPR UNITS AVAILABLE FROM LAERDAL MEDICAL CORP. (select one)

Resusci Anne Complete	_____	Resusci Junior	_____
Resusci Anne Torso Complete	_____	Resusci Baby Complete	_____
Little Anne Four Pack	_____	Little Anne AED Training System	_____

Sponsored by: ____

(Dealership Name & Phone Number)

____

(Contact Name at Dealership)