



**Critical Care Emergency Medical Transport Program  
 Registration Form**

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Degree: (check one)     EMT-P     RN     MD     RT     Other: \_\_\_\_\_

Company/Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

E-Mail Address \_\_\_\_\_

**CCEMTP Course Dates:**

February 8-26, 2010      \$1,000

June 7-25, 2010      \$1,000

September 7-24, 2010      \$1,000

**Credentials**

Please include appropriate copies of your professional credentials:

EMT-P, RN, MD, RT

BLS

ACLS

PALS/PLS/PEPP

BTLS/PHTLS/TNCC

**Make checks/money-orders payable to:**

Medical College of Georgia

**Mail to:**

MCG Dept. of Emergency Medicine  
 EMS Academy  
 Attn: CCEMTP Course Coordinator  
 1120 15th Street, AF-2044  
 Augusta, GA 30912

**Fax to:**

706-721-7718, Attention: CCEMTP Course Coordinator

**Credit Card Information:**

Card Type:  MC     Visa

Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_ 3 Digit Security Code \_\_\_\_\_

Name on card \_\_\_\_\_

Signature \_\_\_\_\_