Resuscitation Council UK

Provider Course Centre Application Form

Resuscitation Council UK reserves the right, under The Late Payment of Commercial Debts & (interest) Act 1998, to charge base rate interest if payment is not received within 30 days of date of invoice.

Please complete this form and email it to lms@resus.org.uk.

Course type	**ALS** ☐ **EPALS** ☐ **NLS** ☐ **ARNI** ☐ **FEEL** ☐ (please specify)

Course Centre Details		
Name of Course Centre		
NHS Hospital / Trust or other (If 'other' please provide full details)		
Address (must include postcode)	Postcode	
Hospital / Trust website		

Contact Details for Course Centre Administrator **This is the contact for the Learning Management System**		
Name of Administrator		
Email		
Telephone number		
Address (if different from above)	Postcode	

Contact Details for Course Director	
Name of Course Director	
Job Title	
Email	

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Contact details for Medical Director (if the Course Director is not the Medical Director)				
Name of Medical Director				
Job Title				
Email				
How many candidates per course do you anticipate?	External candidates		Internal candidates	
Please include details of your prospective first course:				
Please indicate how many courses you would like to run per year:				
Please confirm you can meet the requirements of the course Regulations and Equipment List:				

Course Specific Requirements
Please fill in the section relevant to your application. Additional information may be supplied in a supporting statement.

ALS	
Outline the reasons why you are applying for ALS Course Centre status.	

EPALS	
Outline the reasons why you are applying for EPALS Course Centre status.	

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NLS / ARNI (please specify)	**NLS** ☐ **ARNI** ☐
Outline your current Neonatal/ Obstetrics /Midwifery services and the reasons why you are applying for NLS / ARNI Course Centre status. **(ARNI Course Centres must be established NLS Course Centres).**	

FEEL	
Outline the reasons why you are applying for FEEL Course Centre status	

I hereby apply to run the ALS☐ EPALS☐ NLS☐ ARNI☐ FEEL☐ (tick as appropriate) provider course at the above Course Centre. I confirm I have read the appropriate provider course Regulations. On behalf of the Course Centre, I agree to comply with the provider course Regulations as set out by RCUK.	
Course Director signature	
Please print name	
Date	

Hospital/Trust Executive Director or Dean Details	
I support this application for Hospital/Trust to become an RCUK Course Centre and confirm the details on this form are correct.	
Authorising signature of Hospital / Trust Executive Director/Dean (electronic signature accepted)	
Please print name	
Job title	
Email	
Date	

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FOR RCUK USE ONLY						
Checked by						
Information complete?						
Web check completed?						
Further details required?						
Date						
Approved by Subcommittee?	Yes		No		Date	
Subcommittee comments						