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**Affiliation Application/Instructor Information Form**

Name:  Title: ****

Social Security #: Level of Licensure: 

(Ex: RN, EMT-p, etc)

Mailing Address: 

 Home/Cell Phone: 

 Email: 

**Have you ever been affiliated with another Training Center?  **

**If Yes, which Training Center? **

Contact Name:  **** Phone: ****

Please check all that apply regarding your current Instructor Status.

**Include a copy of all cards that apply**.

 **BCLS/PBLS ACLS PALS**

Regional Faculty: Regional Faculty: Regional Faculty:Instructor/Trainer: Instructor: Instructor:

Instructor: 

**You must also include any documentation verifying Instructor Course completion.**

**Please complete affiliation payment by visiting our Instructor Website at www . wfubmc . edu/tc**

**Please complete this form and email to:**

**lifesupported@wakehealth.edu**

**or mail to:**

**Training Center - Dept 696**

**Medical Center Boulevard**

**Winston-Salem, NC 27157**