LEARNER REGISTRATION FORM

COURSE NUMBER:	

CERTIFICATE INFORMATON

Please complete in CAPITAL letters.
Please ensure that you name is **completely legible** as re-issue of an incorrect certificate carries an added cost which will be borne by you.

FULL NAME																						
POSTAL ADDRESS																						
Street																						
Town																						
County																						
EIRCODE																						

Note: your postal address is deleted when your certificate has issued.

DATA PROTECTION CONSENT

YES	NO

I consent to the Instructor or the PHECC recognised institute contacting me by email when my training is due for renewal.

[INSERT √ Above]

EMAIL – ADDRESS																					

Your name and email address will be kept on file by the course instructor / Pre-hospital Emergency Care Council [PHECC] recognised institute for 2 years and 3 months after which time they will be removed. Your email address is not shared with the Pre-hospital Emergency Care Council and/or any a third party.

STUDENT AGREEMENT

I agree to treat my fellow learners and the course instructors with dignity and respect always. I recognise that the management of **safety**, health and welfare is of fundamental importance and I will follow the instruction/s given by the instructor should the need arise.

SIGNATURE	
DATE