

Progressive Rescue Solutions, Inc.
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The name you list below will appear on your Certificate of completion, and your Certificate will be sent to the address listed. **Please Print**

Name _____ Date of Birth _____

Address _____

City _____ St _____ Zip _____

Home Phone _____ Cell _____

E-Mail Address _____

Medical Training: Paramedic _____ EMT _____ First Responder _____ Other _____

Department or Agency Information

Agency _____

Address _____

City _____ St _____ Zip _____

Supervisor or Department Contact (Name & Phone) _____

Brief Medical Information

Do you have any pre-existing medical conditions? Yes _____ No _____ Explain _____

Do you have any allergies to medicines or environmental? Yes _____ No _____ Explain _____

Do you carry any medical insurance? Yes _____ No _____ If yes please list Insurance Co. or

Provider _____

Signature: _____ Date: _____ Student # _____

Print Name: _____