



**AEC**

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**ASSOCIATES IN EMERGENCY CARE**

# **NREMT Practical Exam Registration Form**

**Name (Last, First, MI):** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Phone Number: (Day)** \_\_\_\_\_ **(Evening)** \_\_\_\_\_

**Email address:** \_\_\_\_\_ **Exam Date:** \_\_\_\_\_

**Level at which you are testing (please circle):**    **NREMT-Intermediate**    **NREMT-Paramedic**  
**Practical station registering for (please circle):**    **\$35/station or \$200 for all**

**All Stations**    **Static Cardiology**    **Dynamic Cardiology**    **Oral Boards**    **IV Therapy**

**Adult Vent. Mgmt.**    **Dual Lumen Airway**    **Peds. Vent. Mgmt.**    **Pediatric IO**

**BLS Random-specify which (\_\_\_\_\_)**    **Trauma Pt Assessment**    **Medical Pt Assessment**

**Please make check or money order payable to "AEC" and mail payment in with this form.**

**If paying by Visa or MasterCard, complete this information and fax the form to AEC.**

**Card Number** \_\_\_\_\_ **Amount \$** \_\_\_\_\_

**Name as it appears on the card** \_\_\_\_\_

**Exp. Date (mm/yy)** \_\_\_\_\_ **Please circle card type:**        

**Security Code (CVV) Three digit code on back of card** \_\_\_\_\_

**Cardholder's Signature** \_\_\_\_\_

**A non-refundable fee of \$25 will be charged to any cancellations made more than 2 weeks prior to the exam date. Registrant who fail to attend the exam or cancel less than 2 weeks prior to the exam date will be subject to forfeiture of the entire registration fee.**