

Hands-Only CPR Training Roster/Sign-in Sheet

Event Name: _____ Event Date: _____

Event Address: _____ City _____ St _____ Zip _____

Facilitator(s) Name: _____

Facilitator Email or Phone: _____

Training Type (circle one): Video Only | Video + Psychomotor | Demo + Psychomotor

Number of People Trained: _____

Which Hands-Only CPR Video did you use? _____

Participant First Name and First Initial of Last Name

(Please only sign in with your **FIRST NAME** and **FIRST INITIAL** of your last name)

	FIRST NAME	FIRST INITIAL of Last Name		FIRST NAME	FIRST INITIAL of Last Name
1			16		
2			17		
3			18		
4			19		
5			20		
6			21		
7			22		
8			23		
9			24		
10			25		
11			26		
12			27		
13			28		
14			29		
15			30		

Continued

Participant First Name and First Initial of Last Name

*(Please only sign in with your **FIRST NAME** and **FIRST INITIAL** of your last name)*

	FIRST NAME	FIRST INITIAL of Last Name		FIRST NAME	FIRST INITIAL of Last Name
31			56		
32			57		
33			58		
34			59		
35			60		
36			61		
37			62		
38			63		
39			64		
40			65		
41			66		
42			67		
43			68		
44			69		
45			70		
46			71		
47			72		
48			73		
49			74		
50			75		
51			76		
52			77		
53			78		
54			79		
55			80		