



Please print or type.

**To be completed by the Training Center Director**

Training Center ID \_\_\_\_\_

Please check the box to indicate that **NEW** information is being provided for this Training Center (TC):

Options	Current Information
<input type="checkbox"/> TC Name*	
<input type="checkbox"/> TC Director*	
<input type="checkbox"/> TC Mailing Address	
<input type="checkbox"/> TC Billing Address	
<input type="checkbox"/> TC Director Email	
<input type="checkbox"/> TC Phone #	
<input type="checkbox"/> Authorized Purchasers	

*\*If your Training Center has terms with ASHI and the liable party approved for terms has changed, the center will be required to submit a new credit application under the new liable party name for approval.*

### Other Updates

Do you have tax-exempt status?  Yes *(Please attach documentation.)*  No

ASHI may send me promotions, advertisements, and newsletters by email.  Yes  No

Business Structure: Do you offer classes to the public for a fee?

Yes (Entrepreneurial)

No Please indicate your business structure:  Corporate  Government/Non-profit  Healthcare/EMS

Do you have \$1,000,000,000 in professional liability insurance? *(Required for Training Centers offering ACLS or PALS.)*

Yes *(Please attach a copy of the certificate of liability insurance.)*  No

Have you ever had a license or certification suspended, revoked, or denied, or been convicted of a felony in any state?

No  Yes *(If yes, you may still be eligible to direct a Training Center, but you must attach a detailed explanation.)*

### Training Center Agreement

I understand and agree for myself and all other persons acting on my behalf or on behalf of my Training Center that approval as an ASHI Training Center is a privilege, not a right, and may be revoked. My Training Center will provide programs in accordance with the most recent version of the Training Center Administrative Manual (TCAM) hereby incorporated by reference. I will inform ASHI immediately of any changes to information on this form or on the application forms of all affiliated Instructors. (To view the TCAM go to [www.ashinstitute.org/quality.htm](http://www.ashinstitute.org/quality.htm))

TC Director Name *(Please print)* \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS APPLICATION MAY BE MAILED OR FAXED TO:**

**Northeast American Safety Network, LLC**

**PO Box 67**

**Poquonock, CT 06064**

**877-233-2779**

**Fax 860-298-0686**

**[Christine@neasn.com](mailto:Christine@neasn.com) [www.neasn.com](http://www.neasn.com)**