

## **Triton College - Health Career Program Requirements**

The following requirements are to be completed, and submitted to the Health Services Department **within 30 days of the date that this packet is due. The due date is determined by your program coordinator.**

### **Submit Packet to CastleBranch- Health Services**

Location: <https://mycb.castlebranch.com/>

Phone No: 888-666-7788

Days available: Monday – Friday & Sunday

### **Requirements**

#### **Completed by: Medical Provider**

1. **Physical Exam** – complete attached form
2. **Quantiferon Gold Blood Test** – attach laboratory result
3. **Rubella Titer (IGG)** – attach laboratory result
4. **Rubeola Titer (IGG)** – attach laboratory result
5. **Varicella Titer (IGG)** – attach laboratory result
6. **Mumps Titer (IGG)** – attach laboratory result
7. **Hepatitis B Titer** – attach laboratory result
8. **Hepatitis B Vaccine Series** – attach vaccine documentation
9. **Tetanus, Diphtheria, and Pertussis (Tdap) Booster** – attach vaccine documentation
10. **Flu Vaccine** - (Program Specific - check with instructor - attach M.D. documentation)
11. **10 panel Drug Test & Alcohol Test** - (Program Specific - check with instructor - 2 separate tests - attach laboratory result for both)

#### **Completed by: Student**

12. **Health Care Provider CPR** - attach CPR card
13. **Hospitalization Insurance** - attach Health Insurance Card & Keep Current
14. **Authorization for Release/Exchange Information Form** - completed by the student
15. **Indemnification and Release Form** – completed by the student
16. **Health Requirement Contract** – completed by the student
17. **Confidential Medical History Form** – completed by the student
18. **Copies** – keep a copy & submit a copy (in checklist order) to Triton College Health Services

# Checklist

*This Checklist is to be completed by a  
Triton College Nurse  
Dates Required for Rad Tech Students*

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Health Program Month/Year

\_\_\_\_\_  
Physical Exam

**Physical update due by:** \_\_\_\_\_

\_\_\_\_\_  
Quantiferon Gold Blood Test

**Annual Quantiferon Gold update due by:** \_\_\_\_\_ & \_\_\_\_\_

\_\_\_\_\_  
Rubella Titer (IGG)

Date +/-

\_\_\_\_\_  
Rubeola Titer (IGG)

Date +/-

\_\_\_\_\_  
Mumps Titer (IGG)

Date +/-

\_\_\_\_\_  
Varicella Titer (IGG)

Date +/-

## MMR Booster

Booster #1 done on: \_\_\_\_\_

**Booster #2 or + Titer due by:** \_\_\_\_\_

Booster #2 or + Titer done on: \_\_\_\_\_

## Varicella Booster

Booster #1 done on: \_\_\_\_\_

**Booster #2 or + Titer due by:** \_\_\_\_\_

Booster #2 or + Titer done on: \_\_\_\_\_

\_\_\_\_\_  
Hepatitis B Titer (HBsAg or HBsAb or HBcAb)

Date +/-

## Hepatitis B Booster

Hep B Series (3 Vaccines) received in the past? Yes/No/Unknown

Booster #1 done on: \_\_\_\_\_

**Booster #2 or + Titer due by:** \_\_\_\_\_

Booster #2 or + Titer done on: \_\_\_\_\_

**Booster #3 due by:** \_\_\_\_\_

Booster #3 done on: \_\_\_\_\_

**+ Titer due by:** \_\_\_\_\_

+ Titer done on: \_\_\_\_\_

\_\_\_\_\_  
10 Panel Drug Test and Alcohol Test - (Program Specific - check with instructor)

Date +/-

\_\_\_\_\_  
Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine

Date

**Tdap booster due by:** \_\_\_\_\_

\_\_\_\_\_  
Seasonal Flu Vaccine (Due by Oct. 1 annually)

**Seasonal Flu Vaccine update done on:** \_\_\_\_\_ & \_\_\_\_\_

\_\_\_\_\_  
Current CPR Card

**CPR update due by:** \_\_\_\_\_

\_\_\_\_\_  
Hospitalization Insurance (Type): \_\_\_\_\_

**Annual Insurance Verification due by:** \_\_\_\_\_ & \_\_\_\_\_

\_\_\_\_\_  
Triton College Forms

- Authorization for Release and/or Exchange of Health and Other Information Form
- Indemnification and Release Form
- Health Requirement Contract
- Confidential Medical History

Triton College Health Services Nurse Signature	Date
Copy given to Student:	

**Additional copies given to students are \$10.00**

## **School Physical Examination**

*To be completed within 30 days of the packet due date*

<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>
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	Normal	Abnormal	Comments
1. General Appearance			
2. Skin			
3. Eyes			
4. Ears/Nose/Throat			
5. Hearing			
6. Lymph Nodes			
7. Respiratory			
8. Cardiovascular			
Blood Pressure			
Pulse			
9. Abdomen/G.I.			
10. Musculoskeletal			
11. Joints/Extremities			
12. Neurological			
13. Metabolic/Endocrine			
14. Other			

**Is the student receiving medication or treatment for any health-related problems that may impair his/her ability to perform their clinical duties safely?**

**Yes**\_\_\_\_ **No**\_\_\_\_ If Yes; list and indicate necessary and reasonable accommodations to permit the student to perform clinical duties.

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**Does the student have restrictions or limitations in performing their clinical duties safely?**

**Yes**\_\_\_\_ **No**\_\_\_\_ If Yes; list and indicate necessary and reasonable accommodations to permit the student to perform clinical duties.

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Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider Stamp

**Authorization for Release and/or Exchange of  
Health and Other Information**

**I authorize Triton College to release and/or exchange the following information about me (check one):**

- ☐ Any information in my health services record.
- ☐ Other (please specify) \_\_\_\_\_

**Person or agency with which Triton College Health Services may exchange information:**

- ☐ Person/Agency: Triton College/Clinical Sites/CCMSI/Guardian/Personal Healthcare Providers/Illinois State Police Bureau of Identification/U.S. Department of Justice Federal Bureau of Investigation
- ☐ Other: \_\_\_\_\_

**This consent is valid until (check one):**

- ☐ The completion of my academic career at Triton College
- ☐ Specific date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that I may revoke this consent at any time and that the above named person/agency with which Triton College is authorized to exchange information has the right to inspect or copy the information to be disclosed.

It has been explained to me and I understand that if I refuse to consent to this release of information, the Triton College Health Services staff's ability to assist me may be hindered.

By signing this release, I further agree to hold harmless and indemnify Triton College, its officers, agents, trustees and employees against any losses, damages, judgments, claims, expenses, costs and liabilities imposed upon or incurred by or asserted against Triton College, its officers, agents, trustees or employees, including reasonable attorneys' fees and expenses, arising out of a release of health and other information consistent with this release form.

<b>Student Signature</b>	<b>Guardian Signature</b>	<b>Relationship to the Student</b>	<b>Date</b>
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NOTE TO PERSON/AGENCY EXCHANGING INFORMATION; under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act you may not re-disclose any of this information unless the above signed client specifically consents to such disclosure. Under the Federal Act of July 1, 1975, confidentiality of alcohol and drug abuse patient records, no such records or information from such records may be further disclosed without specific authorization for such re-disclosure.

## **Indemnification and Release Form**

I agree to hold harmless and indemnify Triton College, its officers, agents, trustees and employees against any losses, damages, judgments, claims, injuries, expenses, costs and liabilities imposed upon or incurred by or asserted against Triton College, its officers, agents, trustees or employees, including reasonable attorneys' fees and expenses, arising out of my acts or omissions while participating in my clinical rotation as a part of my educational program at Triton College.

I fully release Triton College and shall assume all such costs, losses, damages, injuries, claims, demands and expenses of any lawsuit, legal proceeding, defense or settlement. Additionally, I shall pay all judgments entered in any such suit or other legal proceedings.

My obligations under this indemnity and release form shall continue and remain in full force and effect beyond the conclusion of the clinical rotation and Triton College's academic year.

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**Student Signature**

Guardian Signature

Relationship to the Student

**Date**

## **Health Requirement Completion Contract**

I agree that I am solely responsible for submitting, updating and keeping my health requirements up-to-date, with the Triton College Health Services department.

I understand the clinical sites mandate these health requirements, and demand each health requirement has been met and kept current in order to attend clinical, at their health care facility.

I understand that it is imperative to submit all health requirements to the Triton College's Health Services department, prior to their expiration. Dates of expiration can be located on the checklist of my health packet.

My obligations to comply with submitting and keeping my health documentations up-to-date is essential for securing clinical locations months in advance. Therefore, I agree, that if my health requirements lack approval by the Triton College's Health Services department, by each noted deadline and/or dates of expiration, I will not be able to attend clinical or register for classes.

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**Student Signature**

**Guardian Signature**

**Relationship to the Student**

**Date**

## **Triton College - Confidential Medical History**

Have you had/ Do you have	Yes	No		Yes	No		Yes	No		Yes	No
Rheumatic Fever			Lung Disease			Stomach Problems			Back Problems		
Scarlet Fever			Tuberculosis			Bowel/Colon Problems			Knee Problems		
Mumps			Asthma			Recent weight Gain			Ankle/Foot Problems		
Rubella (German Measles)			Chronic Cough			Recent weight Loss			Wrist Problems		
Rubeola (Measles)			Hay fever			Seizures/Epilepsy			Elbow Problems		
Varicella (Chicken Pox)			Sinus Problems			Dizziness			Shoulder Problems		
Epilepsy			Seasonal Allergies			Fainting			Arthritis		
Head Injury			Heart Disease			Depression			Weakness		
Stroke			High Blood Pressure			Anxiety			Paralysis		
Migraine			Low Blood Pressure			Insomnia			S.T.D.'s		
Gallbladder Problems			Pain/Pressure in Chest			Mental Illness			Surgery		
Liver Disease			Heart Palpitations			Eye Problems			Cancer/Tumor		
Hepatitis			Kidney Disease			Ear Problems			Food/Rx Allergies:		
Jaundice			Frequent Urination			Nose Problems					
Pancreatitis			Bone Problems			Throat Problems			Other:		
Diabetes			Joint Problems			Gum/Teeth Problems					

**If you have answered yes to any of the above please explain on a separate sheet of paper**

1. Which diagnosis you had/have?
2. When you were diagnosed with the medical condition?
3. List any treatment you had or are currently undergoing for the medical condition.

**Signature**

Guardian Signature

Relationship to the Student

**Date**

## **Triton College - Confidential Medical History**

Last Name	First Name	Middle Initial	Health Career Program
Address		City	State Zip Code
Date of Birth	Height	Weight	Drug Allergies Phone
In case of an Emergency please notify:		Relationship	Phone

- 1. Are you fit to perform clinical duties required of you, physically, emotionally and mentally, with or without a reasonable accommodations, when assigned to patients in multiple participating health care settings?** Yes No

If you require accommodations, provide a statement from your medical provider stating the type of accommodations necessary to fulfill your clinical rotations in a safe manner.

Medications you are currently taking: \_\_\_\_\_

- 2. Are you Pregnant?** Yes No N/A

If yes, do you have any restrictions related to your pregnancy? Yes No N/A

If yes, provide a statement from your medical provider regarding your restrictions and the type of accommodations necessary to fulfill your clinical rotations in a safe manner.

I am aware of the physical, emotional and mental requirements of the allied health program in which I am enrolled and certify that my confidential medical history given to both Triton College and my Medical Doctor is both current and accurate. I understand that any false answers or statements made by me in this application will be grounds for immediate dismissal from my enrollment in the Health Career program in which I am enrolled.

Signature	Guardian Signature	Relationship to the Student	Date
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## **Health Requirement Information**

### **Physical Exam**

You are required to have a “school physical exam” which is less comprehensive than a traditional “adult physical”. School Physicals are valid for 2 years, while in the same health career program.

### **QuantiFERON-TB Gold (QFT)**

This must be completed within 30 days, of the packet submission deadline. And must be kept current, meaning another QFT is due within 365 days of your last QFT test. The QFT is a blood test used to detect Mycobacterium tuberculosis, the bacteria that causes tuberculosis (TB). QFT is a modern alternative to the tuberculin skin test (TST, PPD or Mantoux). Unlike the TST, QFT is a controlled laboratory test that requires one visit and is unaffected by previous Bacille Calmette-Guerin (BCG) vaccination.

### **Titers**

Titers are laboratory results that confirm immunity against viruses such as the Measles, Mumps, Rubella, Varicella and the Hepatitis B viruses found in your blood. The presence of IgG antibodies (Not IgM antibodies) indicates a history of past exposure to the virus or vaccination. A positive IgG result indicates that the person tested should be immune to the virus. If your titers were drawn within the last 5 years, we will accept these.

### **Live Vaccine's**

If your Blood Titers (Measles, Mumps, Rubella or Varicella) are either “negative” or “equivocal” you must either, receive 2 booster vaccines, 6-8 weeks apart. Or receive 1 booster vaccine and re-titer within 6-8 weeks. Students may attend their clinical rotation with evidence of receiving their first booster vaccine. The 2 live booster vaccines are recommended for Healthcare Personnel, by the CDC; for more information, please visit:

<http://www.immunize.org/catg.d/p2017.pdf>

### **Tdap**

You must submit evidence of receiving a Tetanus, Diphtheria, and Pertussis (Tdap) Booster within 8 years of the start of your clinical rotation.

### **Hospitalization Insurance**

You are responsible for continuous health and hospitalization insurance coverage during your enrollment in the program. You must provide proof of your insurance to the Health Services Nurse, i.e., insurance card or print out of coverage.

### **Medical & Psychological Conditions/Pregnancy & Postpartum**

Students who have a medical and/or psychological condition (including lifting restrictions/pregnancy/postpartum period) which requires reasonable accommodation to participate in clinical rotations must provide written documentation from a treating provider regarding the condition and the necessary accommodation required to allow for participation in the classroom and clinical components of the program.

## **Hepatitis B Requirement**

Students must **SUBMIT PROOF OF A POSITIVE HEPATITIS B TITER** (serological quantitative hepatitis B surface antibody titer - HBsAb). Ideally, this blood test would have been drawn within 1-2 months after receiving the last Hepatitis B vaccine, of the series.

Students should also **SUBMIT PROOF OF RECEIVING THE HEPATITIS B VACCINE SERIES** (see diagram below of Hepatitis B vaccine types and schedules).

**Students who have never received the Hepatitis B vaccine, may begin the series now. And will be permitted to attend their clinical rotation, with submitted proof of receiving their first vaccine.**

Students who have completed their Hepatitis B series, but never had a blood titer drawn within 1-2 months after the last vaccine in their series, or received a negative titer result within 1-2 months after receiving their last vaccine in their series, must provide proof of receiving a Hepatitis B booster and a re-titer within 1-2 months after receiving that booster.

If the student's second titer is negative, the student will get 2 additional Hepatitis B vaccines (#5 and #6) per the standard schedule of (Energix-B, Recombivax HB or Twinrix) OR 1 additional dose of the Heplisav-B Adult Vaccine. And final titer should be done 1-2 months after the completion of the above stated booster(s). And if this final titer is negative, the student should be considered a non-responder and evaluated and counseled appropriately.

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According to the Center for Disease Control (2015), Hepatitis B is a liver infection caused by the Hepatitis B virus (HBV). Hepatitis B is transmitted when blood, or another body fluid from a person infected with the Hepatitis B virus enters the body of someone who is not infected. This can happen through sexual contact; sharing needles, syringes, or other drug-injection equipment; or from mother to baby at birth. For some people, Hepatitis B is an acute, or short-term, illness but for others, it can become a long-term, chronic infection. Risk for chronic infection is related to age at infection: approximately 90% of infected infants become chronically infected, compared with 2%–6% of adults. Chronic Hepatitis B can lead to serious health issues, like cirrhosis or liver cancer. The best way to prevent Hepatitis B is by getting vaccinated.

In 2015, a total of 3,370 cases of acute hepatitis B were reported to CDC from 48 states. The overall incidence rate for 2015 was 1.1 cases per 100,000 population. After adjusting for under-ascertainment and under-reporting, an estimated 21,900 acute hepatitis B cases occurred in 2015.

<b>Hepatitis B Vaccines</b>	<b>Schedule</b>
Energix-B (GSK)	3 doses (0,1 and 6 months)
Recombivax HB (Merck)	3 doses (0,1 and 6 months)
Twinrix (GSK)	3 doses (0,1 and 6 months)
Hepisav-B (Dynavax)	2 doses (0, and 1 month)

*Additional information regarding Hepatitis B can be found at: <https://www.cdc.gov/hepatitis/hbv/>  
&  
[https://www.acha.org/documents/resources/guidelines/Immunization\\_Recommendations.pdf](https://www.acha.org/documents/resources/guidelines/Immunization_Recommendations.pdf)*

## Healthcare Resources

\*prices and services are subject to change without notice\*

### Uni-Lab

418 N. Austin # 2 A. Oak Park, IL. 708-848-1556 - Lab Draw Fee = \$10.00

\*\*\*\*Bring this handout with you for prices listed\*\*\*\*

Physical		Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR		Quantiferon Gold	\$90
Rubeola	\$10	Rubella			
Mumps	\$10	Varicella			
Rubella	\$10	TDaP		<b>Drug Testing</b>	
Varicella	\$15	Hepatitis B		10 Panel & Breathalyzer	\$35
Hepatitis B	\$15	Seasonal Flu			

### Westlake Occupational Health Center

1111 Superior St. Professional Office Building, Ste. 506, Melrose Park, IL. 708-938-7600

**PLEASE NOTE THIS ADDRESS WILL CHANGE SOMETIME IN APRIL/MAY 2019**

**Call them for their current location**

Physical	\$45	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR		Quantiferon Gold	\$40
Rubeola	\$30	Rubella			
Mumps	\$30	Varicella			
Rubella	\$30	TDaP	\$75	<b>Drug Testing</b>	
Varicella	\$60	Hepatitis B		10 Panel & Breathalyzer	\$85
Hepatitis B	\$50	Seasonal Flu	\$25		

### InOut Labs

6449 Dempster St. Morton Grove, IL. 847- 657-7900

Physical		Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR		Quantiferon Gold	\$90
Rubeola	\$20	Rubella			
Mumps	\$20	Varicella			
Rubella	\$20	TDaP		<b>Drug Testing</b>	
Varicella	\$20	Hepatitis B		10 Panel & Urine Alcohol	\$52
Hepatitis B	\$37	Seasonal Flu			
Rubella, Rubeola, Mumps, Varicella & Hepatitis B	\$99				

### Elmhurst Memorial Occupational Health Services

1200 S. York St. Elmhurst 331- 221-0570

Physical	\$60	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$90	Quantiferon Gold	\$80
Rubeola	\$20	Rubella			
Mumps	\$25	Varicella	\$140		
Rubella	\$25	TDaP	\$75	<b>Drug Testing</b>	
Varicella	\$65	Hepatitis B	\$80	10 Panel & Breathalyzer	\$85
Hepatitis B	\$80	Seasonal Flu	\$25		

### Edward-Elmhurst Walk-In Clinics - Located Inside Jewel-Osco

630-527-3645

10203 W. Grand Ave., Franklin Park/1127 S. York Rd., Bensenville/7525 Lake St., River Forest

Physical	\$89	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$100		
Rubeola		Rubella			
Mumps		Varicella			
Rubella		TDaP	\$64	<b>Drug Testing</b>	
Varicella		Hepatitis B	\$115		
Hepatitis B		Seasonal Flu	\$32		

**Concentra**

Schiller Park - 4200 N. Mannheim Rd. 847-801-5170

Bellwood - 2615 W Harrison St 708-493-0299

Chicago - 614 W Monroe St 708-258-0700

\*\*\*\*\*Lab Draw Fee = \$17.00\*\*\*\*\*

Physical	\$48	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$102	Quantiferon Gold	\$138
Rubeola	\$44	Rubella		CXR	\$52
Mumps	\$49	Varicella	\$179		
Rubella	\$41	TDaP	\$77	<b>Drug Testing</b>	
Varicella	\$59	Hepatitis B	\$94	10 Panel & Breathalyzer	\$89
Hepatitis B	\$62	Seasonal Flu	\$27		

**Walgreens - Take Care Health Clinic**

Central Phone: 800-323-8622

Physical	\$70	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$123		
Rubeola		Rubella			
Mumps		Varicella	\$166		
Rubella		TDaP	\$75	<b>Drug Testing</b>	
Varicella		Hepatitis B	\$110		
Hepatitis B		Seasonal Flu	\$55		

**CVS Pharmacy – Minute Clinic**

Central Phone: 866-389-2727 #4

Physical	\$89	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$135		
Rubeola		Rubella			
Mumps		Varicella			
Rubella		TDaP	\$95	<b>Drug Testing</b>	
Varicella		Hepatitis B	\$145		
Hepatitis B		Seasonal Flu	\$50		

**Costco Pharmacy**

8400 W. North Ave. Melrose Park, IL. 708-397-2905 #4

Physical		Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$55		
Rubeola		Rubella			
Mumps		Varicella	\$90		
Rubella		TDaP	\$58	<b>Drug Testing</b>	
Varicella		Hepatitis B	\$65		
Hepatitis B		Seasonal Flu	\$21		

**Physicians Immediate Care**

4900 N Cumberland Ave. Norridge

5228 N Northwest Hwy. Chicago

4211 N Cicero Ave. Chicago

3909 N Western Ave. Chicago

All other locations visit: [www.Physiciansimmediatecare.com](http://www.Physiciansimmediatecare.com)

\*\*\*\*\*Lab Draw Fee = \$22.00\*\*\*\*\*

\*\*\*\*Bring this handout with you for prices listed\*\*\*\*

Physical	\$45	Vaccines		Quantiferon Gold or Equivalent	
<b>Titers</b>		MMR	\$127	Quantiferon Gold	\$75
Rubeola	\$89	Rubella		CXR	\$84
Mumps		Varicella	\$170		
Rubella		TDaP	\$50	<b>Drug Testing</b>	
Varicella	\$30	Hepatitis B	\$95	10 Panel & Breathalyzer	\$78
Hepatitis B	\$40	Seasonal Flu	\$40		

## **Hospitalization Insurance**

**\*\*\*HEALTH & HOSPITALIZATION INSURANCE IS REQUIRED\*\*\***

**\*\*\*Submit your Health Insurance Card to Health Services\*\*\***

<b>Name</b>	<b>Website</b>	<b>Phone</b>
Health Insurance Marketplace	<a href="http://www.healthcare.gov/marketplace">http://www.healthcare.gov/marketplace</a>	(800) 318-2596
First Agency, Inc.	<a href="http://www.1stagency.com">http://www.1stagency.com</a>	~ For more information call ~ (269) 381-6630

## **CPR Resources**

**\*\*\*Online CPR courses will NOT be accepted\*\*\***

**\*\*\*Acceptable Card: Health Care Provider CPR Card\*\*\***

**\*\*\*Submit your CPR card to Health Services\*\*\***

<b>Name</b>	<b>Address</b>	<b>Phone</b>	<b>Cost</b>
American Heart Association	Triton College	708-456-0300 x 3500	\$75
CPR Associates, Inc.	2616 W. Peterson Ave. Chicago 7240 W Foster Ave, Chicago 9415 S. Western Ave, Chicago <a href="http://www.cprassociatesinc.com">www.cprassociatesinc.com</a>	773-973-6933 773-467-1300 773-973-6933	\$45
Illinois Safety LLC	Visit website or call for times & locations <a href="http://www.IllinoisSafety.com">www.IllinoisSafety.com</a>	630-290-4280	\$50
Living Healthy, Inc.	7234 W. North Ave. Elmwood Park <a href="http://www.livinghealthyinc.com">www.livinghealthyinc.com</a>	708-395-5519	\$45
CPR Training Center, Inc.	240 E. Lake St. Suite 305, Addison <a href="http://www.mycprtrainer.com">http://www.mycprtrainer.com</a>	630-833-2852	\$60
American Heart Association	<a href="http://www.heart.org/eccclassconnector">http://www.heart.org/eccclassconnector</a>	877-242-4277	Prices Vary