

# TB Basic Course Roster

You can type your information directly into this form. You will not be able to save; print before closing.

Please complete and fax to **317-819-1187** or email back to **TB-IN@Lung.org**

or mail to **American Lung Association in Indiana**

**115 W Washington St, Ste 1180-S**

**Indianapolis, IN 46204**

## INSTRUCTOR

Name \_\_\_\_\_ Email \_\_\_\_\_  
Course Information:  
Date \_\_\_\_\_ Time \_\_\_\_\_ Location of Class \_\_\_\_\_

## PARTICIPANTS

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
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Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
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Practicum  Yes  No

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Address \_\_\_\_\_  
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Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

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Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Pre-test Score \_\_\_\_\_ Post-test Score \_\_\_\_\_  
Practicum  Yes  No