



# TB INSTRUCTOR 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

### TRAINER

Name \_\_\_\_\_ Email \_\_\_\_\_

Course Information:

Date \_\_\_\_\_ Time \_\_\_\_\_ Location of Class \_\_\_\_\_

### PARTICIPANTS

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____

  

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____

  

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____

  

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____

  

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____

  

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____

  

Name _____	Name _____
Email _____	Email _____
Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No
Test Score _____	Test Score _____