POLST TRAINING REGISTRATION

POLST Facilitator (Last Steps) Training Course

With Respecting Choices® certified instructors: Lynn MacKenzie & Patricia Bresser

Course Date: ______________________

Registration Fee: $300.00

Location: ______________________

Includes online training modules, e-manual, full training day on date selected, light breakfast and lunch on day of training

Location: St. Cloud Hospital - Conference Center or Plaza, St. Cloud, MN. Location TBD

SPACE IS LIMITED. QUICK REGISTRATION ADVISED!

The purpose of this program is to improve the effectiveness of the POLST paradigm program through facilitation skills training and prepare participants to become certified as Respecting Choices (RC) Last Steps® ACP Facilitators. It is for health care professionals and others who have end of life discussions as a component of professional practice to initiate and help individuals establish medical and non-medical goals of care.

Course Objectives:

At the conclusion of this educational activity, the participant should be able to:

1. Describe the purpose of the Last Steps ACP (POLST paradigm) program.
2. Identify skills to initiate Last Steps ACP conversations with persons with serious life-limiting illness, designated healthcare agents, and their loved ones.
3. Identify skills to assist in making informed treatment decisions, to include CPR, limitations on treatment, and comfort care.
4. Practice Last Steps ACP conversations.
5. Identify techniques to create a POLST document that accurately reflects an individual's treatment preferences.

CEU Credits Available!

Nurses = 14.65

Social Workers = 13.25

Prerequisite: online facilitator training modules*

Please Note:

Because space is limited and there are online components to be completed prior to the day of training, registrations should be submitted as early as possible. ***After registration deadline is closed per class, you will receive an email with instructions for accessing the online training and instructional letters.**

Registration:

FIRST: ______________ MI: ____ LAST: ______________

ADDRESS: ______________________

CITY/STATE: ______________ ZIP: ________ PHONE: ______________

ORGANIZATION NAME: ______________________

WORK ADDRESS: ______________________

WORK CITY/STATE: ______________________ ZIP: ________

PROFESSION: ______________ JOB TITLE: ______________

DEPARTMENT: ______________________

EMAIL: ______________ PHONE: ______________

TOTAL: ____________ FORM OF PAYMENT: Check Enclosed ____ Credit ____

IF PAYING BY CARD:

NAME ON CARD: ______________ CARD NUMBER: ______________

TYPE OF CARD: ________ EXP: ________ 3-DIGIT SECURITY CODE: ________

SIGNATURE: ______________________

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