



LIFESAVING SOCIETY
The Lifeguarding Experts

Airway Management

(Updated 2014)

Side 1: Please print each candidate's name and contact information legibly.

Date of birth	Prerequisite	Knowledge	Barrier devices	Oral airways	Oxygen delivery system	Oxygen supplementation	Manual suction	Result
		1	2	3	4	5	6	
1 Name Address Apt.# City Postal Code E-mail Phone Year Month Day								
2 Name Address Apt.# City Postal Code E-mail Phone Year Month Day								
3 Name Address Apt.# City Postal Code E-mail Phone Year Month Day								
4 Name Address Apt.# City Postal Code E-mail Phone Year Month Day								
5 Name Address Apt.# City Postal Code E-mail Phone Year Month Day								

Check box if there are more candidates on the reverse side of this page. This test sheet is Page _____ of _____ Pages.

- Satisfactory Performance **F** - Fail Total Pass for Exam Total Fail for Exam

Payment information Exam fees attached Exam fees not attached

Send invoice or receipt to:

Host name (Affiliate) _____ Telephone _____

Street address _____

City _____ Prov. _____ Postal code _____

Exam information

Exam date: ____ YY ____ MM ____ DD Exam is: Original **OR** Recert

Facility name (e.g., name of pool) _____ Telephone _____

Airway Management Instructor information

Instructor's name _____ ID# _____

E-mail address _____

Telephone _____ Signature required _____

This section to be completed by the Airway Management Examiner who examined the candidates.

Name _____ ID# (optional) _____

E-mail address _____

Telephone _____ Signature required _____



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Side 2: **Please print** each candidate's name and contact information legibly.

Date of birth	Prerequisite	Knowledge	Barrier devices	Oral airways	Oxygen delivery system	Oxygen supplementation	Manual suction	Result
		1	2	3	4	5	6	
6 Name Address Apt # City Postal Code E-mail Phone Year Month Day								
7 Name Address Apt # City Postal Code E-mail Phone Year Month Day								
8 Name Address Apt # City Postal Code E-mail Phone Year Month Day								
9 Name Address Apt # City Postal Code E-mail Phone Year Month Day								
10 Name Address Apt # City Postal Code E-mail Phone Year Month Day								

Check box if there are more candidates on the reverse side of this page.
This test sheet is Page _____ of _____ Pages.

- Satisfactory Performance **F** - Fail Total Pass for Exam Total Fail for Exam

Host name (Affiliate) _____
 () _____
 Telephone _____

Please complete Instructor and Payment information sections on Side 1 of the test sheet. Host name, Exam information and Examiner sections must be completed on both sides 1 and 2 of the test sheet.

Exam information

Exam date: ____ YY ____ MM ____ DD Exam is: Original **OR** Recert

Facility name (e.g., name of pool) _____
 () _____
 Telephone _____

This section to be completed by the Airway Management Examiner who examined the candidates.

Name _____ ID# (optional) _____

E-mail address _____
 () _____
 Telephone _____ Signature required _____