



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	
<b>1</b> Name Address Apt # City Postal Code E-mail Phone	Year Month Day							
<b>2</b> Name Address Apt # City Postal Code E-mail Phone	Year Month Day							
<b>3</b> Name Address Apt # City Postal Code E-mail Phone	Year Month Day							
<b>4</b> Name Address Apt # City Postal Code E-mail Phone	Year Month Day							
<b>5</b> 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 is:

Exam date: YY MM DD

☐ 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



LIFESAVING SOCIETY  
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# Airway Management

(Updated 2014)

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	Year								
Address Apt #	Month								
City Postal Code	Day								
E-mail									
Phone									
7									
Name	Year								
Address Apt #	Month								
City Postal Code	Day								
E-mail									
Phone									
8									
Name	Year								
Address Apt #	Month								
City Postal Code	Day								
E-mail									
Phone									
9									
Name	Year								
Address Apt #	Month								
City Postal Code	Day								
E-mail									
Phone									
10									
Name	Year								
Address Apt #	Month								
City Postal Code	Day								
E-mail									
Phone									

☐

Check box if there are more candidates on the reverse side of this page.

This test sheet is Page \_\_\_\_\_ of \_\_\_\_\_ Pages.



Satisfactory Performance



- 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