DAN Registration Form

(Registration Form, Statement of Understanding, Exam Answer Sheet and Practical Evaluation Record are to be retained by the instructor for seven years.)

Course Location ______________________________________ Date ______________________
DAN Instructor __________________________________________________________________

PERSONAL INFORMATION

Name _________________________________  Date of Birth ________  DAN Member #_______
Address ______________________________________
Home Phone ( _____ ) _________________  Mobile Phone ( _____ ) ____________________
Work Phone ( _____ ) ____________________  Fax Phone ( _____ ) _____________________
Email Address ___________________________________________________________________

STATEMENT OF UNDERSTANDING

(Agreement Between DAN Instructor and Student)

Student Initials

_____ I am participating in the Neurological Assessment training program from Divers Alert Network (DAN). Successful completion of this course prepares me to assess an individual’s condition and to collect information useful to a physician.

_____ I further understand that it is my responsibility to maintain current knowledge and skills sufficient to conduct a neurological assessment.

_____ I further understand that it is required that I refresh my Neurological Assessment Provider training every two years, as indicated on the DAN Neurological Assessment Provider course completion card.

_____ I further understand that emergency situations can be dangerous and that exposure to blood and bodily fluids can lead to potential illness. I understand that I can minimize the risk of disease transmission by using appropriate barrier devices and hereby agree to do so.

_____ In consideration of mutually beneficial and valuable covenants and services exchanged herein, the undersigned hereby waives any and all claims against his or her DAN Instructor as well as Divers Alert Network, whether grounded in personal injury, wrongful death, or damage to property arising from the teaching of this course by the undersigned DAN Instructor, and further agrees to indemnify the DAN Instructor and/or DAN from any claims arising or caused by the undersigned’s failure to follow said instruction or breech of any of the above items.

Student Signature _____________________________ Date ______________________
DAN Instructor Signature ______________________________ Date ___________________
Parent or Guardian Signature _________________________ Date ___________________
(Required if student is under 18 years of age.)

Important: The student should complete and sign this form and return it to the DAN Instructor prior to completion of the DAN Neurological Assessment Provider course and certification. A copy of this document can be obtained from your DAN Instructor and is paraphrased on your Provider Card.

(To be retained by the DAN Instructor)
Neurological Assessment
Exam Answer Sheet

The final examination may be administered in written or oral form.
The instructor must review every question with each student so that 100 percent comprehension of the material is ensured.
Questions have only one correct answer.

Name _____________________________________ Date__________ Test Score__________

A  B  C  D  
1 ❑ ❑ ❑ ❑ 11 T □ F □
2 ❑ ❑ ❑ ❑ 12 T □ F □
3 T □ F □ 13 □ □ □ □
4 ❑ ❑ ❑ ❑ 14 T □ F □
5 T □ F □ 15 □ □ □ □
6 T □ F □ 16 □ □ □ □
7 □ □ □ □ 17 □ □ □ □
8 □ □ □ □ 18 T □ F □
9 □ □ □ □ 19 T □ F □
10 □ □ □ □ 20 T □ F □

Neurological Assessment
Practical Evaluation Record

Student Name ________________________________________
Neuro Provider Skills Development Instructor Initials Student Initials
• FAST Assessment _________  _________
• Taking a History _________  _________
• Taking Vital Signs _________  _________
• Mental Function _________  _________
• Cranial Nerves _________  _________
• Motor Function (Strength) _________  _________
• Coordination and Balance _________  _________

I am comfortable with the performance of my skills as a DAN Neurological Assessment Provider.

I have reviewed this examination with the course instructor. I understand the correct response as indicated by my initials. Any questions regarding this examination and the contents of this course have been answered to my satisfaction.

Student Signature ___________________________________________ Date _______________

Neurological Assessment
Practical Evaluation Record

Student Name ________________________________________

Neuro Provider Skills Development Instructor Initials Student Initials
• FAST Assessment __________  _________
• Taking a History __________  _________
• Taking Vital Signs __________  _________
• Mental Function __________  _________
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• Motor Function (Strength) __________  _________
• Coordination and Balance __________  _________

I am comfortable with the performance of my skills as a DAN Neurological Assessment Provider.

I have reviewed this examination with the course instructor. I understand the correct response as indicated by my initials. Any questions regarding this examination and the contents of this course have been answered to my satisfaction.

Student Signature ___________________________________________ Date _______________