

Clayton State University
Center for Continuing Education
Healthcare Certificate Program Application

Student Information

Name: _____ Birth Date ____/____/____
 LAST FIRST MI

- Male Female

Mailing Address: _____
 Street/PO Box City State Zip Code

Phone Number (_____) _____ - _____ Alternate Phone Number (_____) _____ - _____

Email Address: _____

Emergency Contact: _____ Phone Number (_____) _____ - _____

Education

Highest Level of Education attained:

- High School Diploma/GED Bachelor's Degree
 Master's Degree or above Some College

 Name of School Dates Attended

 Address - Street City State Zip Code

Programs

Please select the Certificate Program you are interested in.

- Clinical Hemodialysis Technician** **Clinical Medical Assistant**
 Medical Coding Specialist **Patient Care Technician**
 Pharmacy Technician **Phlebotomy Technician**

Submission Checklist

All items must accompany this application at least 10 business days prior to class start date.

- Application Form
 Copy of Criminal Background Check (may be obtained at local Police Dept., Dept. of Justice or other state agencies)
 2 (Two) Letters of Reference (Professional and/or Educational only)

Applicant Signature

Date