Clayton State University
Continuing and Professional Education

Healthcare Certificate Program Application

Student Information

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

□ Male □ Female WIOA_____ VA_____ Sallie Mae_____ Other _____

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 □ Some College □ Bachelor's Degree □ Master's Degree or above

_____ _____
Name of School Dates Attended

_____ _____ _____ _____
Address - Street City State Zip Code

Programs

Please select the Certificate Program you are interested in.

- □ **Clinical Medical Assistant (Day)**
- □ **Clinical Medical Assistant (Evening)**
- □ **Patient Care Technician (Day)**
- □ **Patient Care Technician (Evening)**
- □ **Medical Billing Specialist**
- □ **Phlebotomy Technician**
- □ **Pharmacy Technician**
- □ **Medical Coding Specialist**

Submission Checklist

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

- **Application Form and Resume**
- **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, Community, and/or Educational only)**
- **Test scores**

_____ _____
Applicant Signature **Date**

Accepted_____ **Declined**_____

Signature_____ **Date**_____