Healthcare Certificate Program Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone:____ _____ Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Programs

Please select the Certificate Program you are interested in.

Clinical Medical Assistant (Day)	***Phlebotomy Technician***
Clinical Medical Assistant (Evening)	***Pharmacy Technician***
Medical Billing Specialist	***Medical Coding Specialist***

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

Accepted: _ _____ Declined: _____

Signature_____ Date: _____