KAUA'I HEALTH CAREER TRAINING

"Caring is Our Business"

Medical Assistant

Enrollment Agreement

Please fill out and mail back (or drop off) these signed forms plus your check in the amount of $275.00 for your registration fee.

This is to reserve your placement in the class.
There are only 12 seats available per class.

This program requires a scheduled interview before you can be accepted as a student into the ECG Technician Program.

Applicant:

Please read this agreement before you sign it. After you sign and Kaua'i Health Career Training accepts your application, you will be bound by the terms of this agreement.

I agree to release and hold harmless the health care facility which provides my clinical experience, its employees and clinics and the Kaua'i Health Career Training Center, for any misconduct or accidents that occur as a result of my participation in Kaua'i Health Career Training Medical Assistant Program

I understand the course policies as outlined in this packet and certify that all statements I have made on this application are true and complete.

ATTENTION: False statements are subject to action that could lead to dismissal from this program.

PLEASE NOTE: : Prior to your interview, at the discretion of the Medical Assistant Program staff, a candidate may reschedule ONE TIME. Request to reschedule must be made at least 14 days to before class start date. After your interview process and acceptance into the Medical Assistant Program, NO REFUNDS will be issued.

Applicant Signature:_____ Date:_____

Accepted By: _____ Date:_____

Course:	Tuition:	Registration:	Books:	NCCT Tests:	Total Cost:
Medical Assistant	**$1130.00**	**$275.00**	**$130.00**	**$90.00**	**$1,625.00**
	Ask About Our Payment Plans		*$50 Discount on Full Payment*		*Price can change without notice*

OFFICE USE ONLY:

Application Fee Paid: $_____ Invoice #:_____ Date:_____ Balance:_____

Tuition Payments Paid: : $_____ Invoice #:_____ Date:_____ Balance:_____

Total Payment: $_____ Invoice #:_____ Date:_____

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Application Form

Name:_____ Sex: M___ F____
Last *First* *Middle*

Social Security Number.: _____-_____-_____ Date of Birth: _____

Address: _____ Apt. No.:_____

City:_____ State:_____ Zip Code:_____

Phone No.:_____ Cell No.:_____ Message No.:_____

Questionnaire:

1. How did you hear about this course?

2. Have you had any kind of experience in care giving/assisting with others' physical or psycho-social needs (i.e. elderly, children, disabled or people with illness)? [ ] Yes [ ] No

If yes, please describe the level and length of the care you provided. Please include experiences you have had as a volunteer, with your family and/or employment.

3. Have you taken any science or health care related course in school or have you had prior training in the medical field? [ ] Yes [ ] No

If yes, please list the course(s)/training you have had:

4. Why do you wish to take this course?

5. What are your long-range goals?

IN FIVE YEARS, I WANT TO BE:

IN TEN YEARS, I WANT TO BE:

6. What do you feel you have to offer to the health care profession?

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Medical Assistant

Information Form

Name:_____ **Sex: M___ F____**

Date of Birth: _____

Address: _____ **Apt. No.:**_____

City:_____ **State:**_____ **Zip Code:**_____

Phone No.:_____ **Cell No.:**_____ **Message No.:**_____

Email Address: _____