1059 Kilauea Ave.,Ste B, Hilo HI 96720

Ph: (808) 933-1295 Fax: (808) 961-2507

Email: education@hihts.org website: hihts.org

APPLICATION FOR MEDICAL ASSISTANT TRAINING PROGRAM

Name: ____ Social Security No.: ______________

Address: ____________________________ Phone: (Residence): ___________________

____________________________ (Cell)__________ (Work)_______________

DOB: ____________________________

Email (please print)____

Are you 18 years age or older? [ ]Yes [ ]No

What languages do you speak? ____

U.S. Citizen? [ ]Yes [ ]No Alien/Green Card? [ ] Yes [ ] No Alien Card #:__________________

How did you hear about Hawaii Institute of Healthcare and Training Services?_____________________

Have you ever been convicted of a crime or had traffic violation(s) by any court? [ ] Yes [ ] No

(If Yes, please explain nature of the incident and current status) __________________________________

____

If applicable, will you be able to provide letters from your probation officer? ______________________

If Applicable, will you be able to provide at least three (3) letters of recommendation? _______________

Emergency Contact Person: ___________________________________ Phone: _____________________

Address: ____

SCHOLARSHIP INFORMATION (If applicable)

Course Code	**Cost**	**Course Title**	**Date(s)**	**Time**

Company/Agency Name: _______________________________ Contact Person: ______________________

Address: ____ Phone: _______________

____ Fax: _______________

Covered Cost

FOR OFFICE USE ONLY

Registration No.: ________________________ **Acct. No.** _______________ **Initial:** ___________

NON-REFUNDABLE PRE –REGISTRATION FEE: $300.00

TO REGISTER PLEASE CALL: 933-1295 or go online at hihts.org

H.I.H.T.S
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STUDENT AGREEMENT

I ____________(student name), agree to release and hold harmless Hawaii Institute and Healthcare & Training Services, its staff and clients, who provide my training and clinical practice from any accidents or misconduct that arises during the period of my training.

I certify that all statements made here on this application are true to my knowledge and agree to pay all tuition costs.

_______________________________ _______________________________ _________________

Printed name Signature Date

I give consent to use any video, photography, digital images, testimonials on HIHTS website, Facebook and Instagram to promote any and all classes. (If signature is not provided, consent is not given)

___________________________ _________________________ ___________________

Printed Name Signature Date

***AMISSION REQUIREMENTS*:**

- Negative Covid test (Optional)
- Completed application form
- Pre-Screening Test complete, Passing
- Eighteen (18) years of age or older
- High school graduate or G E D
- Computer Literate
- No Criminal record of any kind

OTHER REQUIREMENTS:

1. Scrub uniform
2. White Shoes
3. Notebook/Pen/Pencil
4. Must have a computer or laptop.

SCHEDULE OF CHARGES:

$250.00 **Non-Refundable Pre-Registration**
$519.00 1st Week of Class
$519.00 2nd Week of Class
Total cost $1,700.00

TUITION DISCLAIMER:

Failure to pay may result in cancellation of registration or suspension of class. Only cash, cashier's checks are accepted.
Checks payable to: **Hawaii Institute Healthcare & Training Services (HIHTS.)**

Signature of Student: ____ Date: ___________________

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