INTREPID HEALTHCARE TRAINING ENROLLMENT AGREEMENT

STUDENT INFORMATION

Student Name: _____

Address: _____

City/State/Zip: _____

Home Number:_____Mobile Number:_____ SSN: _____

E-mail: _____

Emergency Contact: _____ Number:_____

PROGRAM INFORMATION

Name of Program: Nurse Assistant Training Program – NA / Patient Care Technician – PCT
(Circle One)

Program Start Date: _____ Anticipated End Date: _____

Program 1-Patient Care Technician	**Hours of Completion**
Number of Weeks - PCT	**6**
Total Clock Hours - PCT	**60**
Program 2-Nurse Assistant	**Hours of Completion**
Number of Weeks -NA	**5**
Total Clock Hours-NA	**100**
Program 3-Nurse Assistant (2-week)	**Hours of Completion**
Number of Weeks-NA	**2**
Total Clock Hours-NA	**100**

Withdrawal: Student(s) who wish to withdraw from this institution after classes begin will be subject to the below refund policy. The institution may retain up to $75 registration fee after the three-day cancellation or after classes begin. Refunds are computed in ten-percent increments, rounded downward to the nearest ten percent of that period. After sixty percent of attendance, the institution may charge for the entire course. Refunds are issued within 40 days after the effective date of cancellation or last date attended. Student(s) who wish to withdraw must notify the school in writing expressing their desire to withdraw from the program with the effective date.

Refund Chart (for a 100-hour program):

Hours Attended	Tuition Refund
1-12	90%
13 – 24	80%
25-36	70%
37-48	60%
49-60	50%
61-72	40%
73-100	0%

Refund Chart (for a 60-hour program)

Hours Attended	Tuition Refund
1-6	90%
7-12	80%
13-18	70%
19-24	60%
25-30	50%
31-36	40%

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Knowing risks exist, nevertheless, I hereby agree to assume those risks and to release and to hold harmless all persons or agencies mentioned above that might otherwise be liable to me or my heirs or assigns for damages. I further understand and agree that this waiver, release and assumption of risk is to be binding on my heirs and assigns.

In addition, I give permission to receive, if necessary, emergency medical services by authorized personnel, and that may cost incurred as a result of such medical treatment will by my responsibility.

Student Name Print:_____ Date: _____

Student Name Signature:_____ Date: _____

School Administrator/Official Name Signature: _____ Date: _____