REGISTRATION FORM

Please complete form and mail to: Providence Health Career Institute, 4600 Valley Road, Suite 412, Lincoln, NE 68510
For online form submission: Email completed form to providencehealthcareer@gmail.com
If you purchase an item on the Providence website, you are registered and do not need to complete this registration form.

Name (First, Middle Initial, Last): _____

Address: _____ Date of Birth: _____

City: _____ Home or Cell Phone: _____

State: _____ Zip Code: _____ Email Address: _____

TRAINING, EXAMS AND PRODUCTS

___ Medication Aide Competency Training & Assessment; Fee: $120.00

___ Medication Aide Skills Review Packet Emailed; Price: $8.00 ___ Medication Aide Skills Review Packet Mailed; Price: $10.00

___ Medication Aide 40 Hour Examination; Fee: $30.00 Date: _____ Location: _____

___ Medication Aide 40 Hour Examination – Oral Exam (Arranged); Fee: $30.00

___ Medication Aide Competency Assessment (Arranged); Fee: $50.00

___ One-Hour Abuse Inservice (Online); Fee: $25.00

PAYMENT INFORMATION Payment in full is due to complete registration. Payment by mail can be submitted by money order.

*Personal checks are not accepted. Total Amount: _____

___ I am submitting this form online and will mail my money order payment (registration is not complete until money order is received).

___ Debit or Credit Card: ___ VISA ___ MasterCard ___ Discover ___ American Express

Cardholder Name (Exact Name on Card): _____

Credit Card Number: _____ Expiration Date: _____

Cardholder Billing Address: _____ Three-digit code on back of card: _____

City: _____ State: _____ Zip Code: _____

Cardholder Signature: _____ Date: _____
(Your signature will authorize this transaction)

For Office Use Only: Administrator Signature: _____ Date: _____