# 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 or fax to: (402) 483-6701

Name (First, Middle Initial, Last): _____

Address: _____ Date of Birth: _____

City: _____ Home or Cell Phone: _____

State: _____ Zip Code: _____ Email Address: _____

## COURSES, EXAMS AND PRODUCTS

___ Nurse Aide Course; Course Fee: $399.00; (Students will purchase a Nurse Aide Textbook, Workbook, & Skills DVD online prior to class)

___ Nurse Aide Skills Review Packet Emailed; Price: $8.00

___ Nurse Aide Skills Review Packet Mailed; Price: $10.00

___ Nurse Aide Competency Testing – Clinical Exam (Arranged); Fee: $30.00

___ Nurse Aide Competency Testing – Written Exam (Arranged); Fee: $20.00

___ Nurse Aide Competency Testing – Oral Exam (Arranged); Fee: $40.00

___ Medication Aide Course; Course Fee: $299.00; (Students will purchase a Medication Aide Student Manual at a bookstore prior to class)

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

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

___ Medication Aide 40 Hour Examination; Fee: $20.00 Date: _____ Location: _____

___ Medication Aide 40 Hour Examination - Oral Exam (Arranged); Fee: $40.00

___ Medication Aide Competency Assessment (Arranged); Fee: $40.00

___ One-Hour Abuse Inservice (Online); Fee: $20.00

___ Nurse Aide Refresher Session; Fee: $80.00

**PAYMENT INFORMATION** (Payment in full is due to complete registration) Total Amount: _____

___ Check enclosed (Make check payable to Providence Health Career Institute, L.L.C.)

___ I am submitting this form online, and will mail my check payment (registration is not complete until check 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: _____

Student Signature: _____ Date: _____

(Your signature will authorize this transaction)

**Cancellation and Refund Policies:** For Nurse Aide and Medication Aide Courses: Cancellation requests received within seventy-two (72) hours of enrollment/registration will receive a full refund and will be issued within thirty (30) days of cancellation. Cancellation requests occurring after 72 hours of enrollment/registration but before the class begins will receive a refund of all tuition paid except a registration fee of $100.00. No refund will be given after a class has started or for failure to attend. Instructor reserves the right to adjust class days and times if necessary. Course may be postponed or cancelled if minimum enrollment of five students is not reached.

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