PREMIER CHOICE HEALTH SERVICES, LLC
NURSE AIDE TRAINING PROGRAM
APPLICATION FOR ADMISSION

Check Box **STNA** ☐ **HHA** ☐

I plan to enroll in the class for ____________________ Date ______________
(Month/Date/Year)

PLEASE PRINT ALL INFORMATION CLEARLY

Full Name ____
Last First Middle

Mailing Address ____
Street City State Zip

Home Telephone Number (____) ________________ Email ________________________________

In Case of Emergency Notify _________________________ Phone Number (____) ____________

How did you hear about us: ☐ Yellow book ☐ Job-news ☐ Columbus Dispatch ☐ Radio ☐ Flyer ☐ Craigslist ☐ Facebook ☐ Myspace ☐ Employment Guide ☐ Merchant Circle ☐ Other _______________

Check one of the following: ☐ Employee of PCHS ☐ Private Pay Student ☐ Facility-Sponsored Student ☐ Industry-Training Student

For Sponsoring Agency Only: To comply with State Regulations, the following information must be completed.
PLEASE PRINT CLEARLY.

Name of Facility ____
Contact Person _______________________________________ Phone Number (__) _______________
Billing Information ________________________________

Important! Read statement and sign below.

I affirm that the information I have provided on this application, including responses to any other information that I have submitted or will submit to Premier Choice Health Services in connection with the admission, is complete and accurate and is my own work. I understand that submission of incomplete or inaccurate information is sufficient cause for revocation of admission or enrollment.

______________________ ______________________ ___ / ___ / ___
Applicant's signature **Print name** **Date**