ACADEMY of MEDICAL PROFESSIONS

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PHLEBOTOMY COURSE ENROLLMENT AGREEMENT

(PLEASE PRINT, MAIL, EMAIL OR FAX REGISTRATION FORM TO ABOVE ADDRESS)

NAME: _____ SS# _____

ADDRESS: _____ DATE OF BIRTH: _____

Gender Assigned at Birth
(choose from dropdown below)

CITY: _____ STATE: _____ ZIP:_____ Female

PHONE NUMBER: _____(H) _____(C)

E-MAIL: _____

LOCATION ATTENDING START DATE _____

Where Did You Hear About Our Courses? _____
If Adult Education brochure or website, which one?_____

PAYMENT METHOD

******Please make checks payable to the Academy of Medical Professions******
$300.00 non-refundable enrollment fee is already included in the price

Please initial

_____I have provided a copy of my current immunizations.

_____I understand that I will be required to participate in performing common phlebotomy practices in this class which requires a number of needle sticks on myself, others in the program and/or volunteers.

_____I understand that I will NOT be required to participate in an externship but will provide consent to the instructor and school should I desire to obtain one and that it is not guaranteed.

_____I understand that there may be a dress code in this field, which may include but not limited to hair color, tattoos and/or piercings.

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SINGLE PAYMENT **CHOOSE ONE**

_____ **$2,500** Phlebotomy, all inclusive program

_____ **$2,500** **Voucher Payment**, Phlebotomy, all inclusive program

VOUCHER PAYMENTS I.E. GOODWILL, DEPT OF LABOR, VA, MYCAA, ETC.

Name of Organization paying and contact information:

_____

_____

PAYMENT PLAN_____(Finance Fees Included)

_____ **$2,775** **$500 Down, $325 a month for 7 months**

CONTRACT AGREEMENT

I, _____ hereby agree to the above mentioned terms of the program. I agree to the payment plan chosen above and I have read and understand the REFUND POLICY for his course and agree to its terms. I agree that if I have a payment plan, that I will keep it in good standing, and that if my account is sent to collections, I am responsible for the legal fees, late fees, and payment plan I have agreed to: SIGNATURE:_____ DATE: _____

PAYMENTS MADE BY CREDIT CARDS

CREDIT CARD # _____

EXPIRATION: _____SECURITY CODE: _____ TYPE OF CARD: _____

NAME AS IT APPEARS ON CARD: _____

BILLING ADDRESS IF DIFFERENT FROM REGISTRATION FORM:

_____

(Check One)

DEPOSIT Amount_$_____Date to take out deposit:_____

(OR)

Payment in **FULL** $_____ Date to take out the full payment:_____

PAYMENT PLAN: Date to begin payments: _____

(THIS INFORMATION IS ONLY NEEDED IF USING PAYMENT PLAN)

DRIVER'S LICENSE # _____ STATE _____