Chosen Healthcare Institute Inc.
705-B Wesley Pines Road
Lumberton, NC 28358
Office: 910-674-4592 Fax: 910-733-9930

Start Date: _____/_____/_____ Check one: Day ( ) Evening ( )
End Date: _____/_____/_____

NAME OF PROGRAM ENROLLING IN: _____

Course Hours: _____ (Class: _____ Lab: _____)

***Chosen Healthcare Institute** has the authority to review any special cases as well as the right to refuse enrollment to an applicant when it is in the best interest of the program or the applicant. Enrollment is due prior to the first day of class. Any enrollment received after will not be accepted.*

Enrollment Requirements:

- ✓ **Application**
- ✓ **Government issued ID w/Picture or Driver License**
- ✓ **Social Security Card**
- ✓ **High School or GED Transcript**
- ✓ **Physical Examination from health provider**
- ✓ **Tuberculosis (TB) Test/Chest X-Ray**
- ✓ **Back ground Check**
- ✓ **Internship: Immunization Record**

Fees:

Non-refundable registration fee **$50.00.** Program for CHCI is $_____ Total payment are due prior to or before the first day of class. The student is responsible to pay for the North Carolina Certification Exam or NHA. The passing of the state exam depends on the student's ability and knowledge of their course. CHCI is not responsible for the failure of the state exam of the students.

Refund Policy:

Refunds will be issued on tuition and fees under the following circumstances:

- A 100% refund shall be made if the student officially withdraws from class before class begins or if class cancels due to insufficient enrollment.
- Refunds will be calculated from the date of withdrawal, which is the last date of actual attendance.
- Written notice of intent to withdraw must be given to the program director.
- Students will be allowed to re-enter the program at a convenient time whining six months or withdrawal at no extra cost
- No refund will be made after student who withdraws unofficially or who has been required to withdraw by the school.
- No refunds will be issued on the registration fee or books.
- No refunds will be issued to a student who was made to drop due to misconduct or poor progress.

Applicant Signature: _____ ***Date:*** _____

** **Note:** Please send a $50.00 non refundable registration fee with this application. No personal checks or cash accepted.*

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APPLICATION FOR REGISTION

Applications are considered without regards to race, religion, nationality, age or handicap.

Start Date: _____/_____/_____ Check one: Day ( ) Evening ( )
End Date: _____/_____/_____

NAME OF PROGRAM ENROLLING IN: _____

Course Hours: _____ (Class: _____ Lab: _____)

Name: (Last) _____ **(First)** _____ **(Maiden)** _____
(Print) (Print) (Print)

Address: _____Apt _____

City: _____ State: _____Zip_____

Telephone #: Home: (____) _____
Cell: (____) _____
Work: (____) _____

Email Address:

_____

Emergency Contact:

_____

Address:

_____

Telephone #: Home: (____) _____
Cell: (____) _____
Work: (____) _____

Applicant Signature: _____ ***Date:*** _____

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APPLICATION FOR REGISTION (Continued)

Name of High School Attended:_____

Address: _____

Did you graduated High School Diploma or received your G.E.D? **YES ( ) NO ( )**

Did you graduate College? **YES ( ) NO ( )**

Number of years of Education (Circle one): 8 9 10 11 12

High School Graduation Date: _____ College Graduation Date: _____

***Please provide a copy of High School Transcript or G.E.D Transcript or College Transcript.**

Any other educational experience:
Are you currently in school?

_____

_____

If yes, Where? _____

_____

Do you have you ever been convicted of Felony? ( ) YES NO ( )

If Yes, Explain in detail:

_____

_____

What are your career goals in the next 3-5 years?

_____

_____

Other Information (Health Care Experience)

_____

_____

Applicants Signature: _____ ***Date:*** _____

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APPLICATION FOR REGISTION (Continued)

TUITION: $_____ [INCLUDING THE $ 50.00 REGISTRATION FEE (NON REFUNDABLE)]

Payment Choice: Cash ____ Money Order/Cashier Check: ____ (***NO PERSONAL CHECKS)***

Registration Fee $_____ Date: _____ Receipt #: _____ CHCI Pep's Signature _____

1st Installment $_____ Date: _____ Receipt #: _____ CHCI Pep's Signature _____

2nd Installment $_____ Date: _____ Receipt #: _____ CHCI Pep's Signature _____

3rd Installment $_____ Date: _____ Receipt #: _____ CHCI Pep's Signature _____

***Payments are strictly according to chosen plan. There is a service charge of $ 10.00 when payment is made in *installmen*t and a late charge of $25.00 in applicable to each late installment. Failure to pay appropriately will invalidate the contract / result to withdraw from class immediately.**

SOURCE OF PAYMENT:

☐ **Personal:** ☐ **WIOA** ☐ **Vocational Rehab** ☐ **Other: _____**

Applicants Signature: _____ ***Date:*** _____

Witness (School Official): _____ ***Date:*** _____