



**Non-refundable \$40
Must accompany this
Application**

Student Information

Please Print

SS # _____

Last Name _____ First Name _____ M.I. _____

Date of Birth _____ Age _____ Gender _____ Race _____

Address _____ City _____ Zip Code _____

Phone Number _____ Email _____

Emergency Contact

Name _____

Phone Number _____

Program Information

Check One:

- Phlebotomy Technician
- Phlebotomy Refresher
- Clinical Medical Assistant
- Patient Care Technician
- Pharmacy Technician
- Home Health Aide
- IV Tech
- "Trinity" Medical Assistant~ Phlebotomy~ ECG

Date to enter program.

I agree to the following tuition \$ _____. If I decide not to attend class, I must withdraw according to Genesis Allied Health Services LLC policies. If I fail to properly withdraw a refund will be issued according to Genesis Allied Health Services LLC policies. I have read and agree to all policies included in the school catalog.

Student Signature _____

Administrative Officer Signature _____

Date: _____



Genesis Allied Health Services LLC
ENROLLMENT APPLICATION

COURSE _____

TODAY'S DATE _____

(APPLICANT INFORMATION)

Are you using WIOA assistance to pay
for the course Yes _____ No _____

Uniform Size _____

Full Name (F, M, L) _____

Home/Mailing Address _____

{Gender} _____ {Race} _____ {Birthdate} _____ {Social Security#} _____

{Driver's License Number/State} _____ {Primary Phone Number} _____

Are you a U.S. Citizen? _____ If not, what is your Citizenship? _____

{Alternate Phone Number} _____ {Email Address} _____

Emergency Contact Person #1 _____

(Relationship) _____ (Phone Number) _____

Emergency Contact Person #2 _____

(Relationship) _____ (Phone Number) _____

(EDUCATION)

High School: _____

Address: _____

Did you graduate? If so, please list the year and month of graduation _____.

Do you have your G.E.D.? _____ (Date) _____

List any allergies/medical alerts:

Please print your name the way you would like to have it printed on your certificate of completion.

Name _____

Date _____

Genesis Allied Health Services LLC provides reasonable accommodations to eligible individuals with disabilities in conformance with Section 504 of the Rehabilitation Act of 1973 and with the Americans with Disabilities Act of 1990. Requests for disability accommodations must be made in a timely fashion to the Director of the program. The address is P.O. Box 1198 Auburn, AL 36831-1198. Students seeking accommodations must submit appropriate medical documentation and comply with the policies and procedures of Genesis Allied Health Services LLC.

I _____ agree to abide by the rules and regulations set forth Genesis Allied Health Services LLC. I understand that Genesis Allied Health Services LLC is a training program and is NOT responsible for providing me with employment nor does the training program guarantee me employment. I also understand that if an externship is included in this training that I am to conduct myself in a professional manner while attending an externship site. I further understand that I am to follow the rules of the externship sites, listen to the externship staff, and treat the staff and patients with the upmost respect. I acknowledge that failure to follow externship rules will disqualify me from completing an externship under Genesis Allied Health Services LLC.

_____ Place your initials here which serves as your acknowledgement and understanding of the statement above.

_____ Place your initials here which serves as your acknowledgement and understanding that the wearing of artificial nails is prohibited for this training program and will need to be removed, especially before externship assignments.

I _____, attest that ALL information provided in this application is true and I understand that any false statements, code of conduct violations, excessive absences from class, and non-payment will disqualify me from the program.

(Signature) _____ (Date) _____

Application Reviewed By: _____

(School Administrator)

For Office Use

<i>Full Completed Application</i>		
<i>Proof of High School Diploma/GED/College Transcript</i>		
<i>Photo ID</i>		
<i>Registration Fee</i>		

Genesis Allied Health Services LLC

P.O. Box 1198

Auburn, AL 36831-1198

Phone: 334-451-0303



Student NON-DISCLOSURE

This Agreement is made by and between Genesis Allied Health Services LLC and

_____ (Student) effective as of _____ (Date).

Genesis Allied Health Services LLC possesses competitively valuable information (as hereinafter defined) regarding current courses, future courses, and business operations.

1. Confidential Information and Materials

(a) "Confidential Information" shall mean any nonpublic information that the company specifically marks and designates, either orally or in writing, as confidential or which, under the circumstances surrounding the disclosure, ought to be treated as confidential.

2. Confidential Information includes study guides, tests, quizzes, activities, textbook/workbook used for the course, curriculum, syllabus, testing agency (for example no dissemination of testing materials), and any other practices within the course deemed confidential by Genesis Allied Health Services. The student shall not disclose any Confidential information without the prior writing authorization of Genesis Allied Health Services LLC. The student shall not at any time disclose to any third party any Confidential information comprising of Genesis Allied Health Services LLC trade secrets or any other party to whom the Company owes and obligation to. However, the student may disclose Confidential information in accordance with judicial or other governmental orders, provided student shall give Genesis Allied Health Services LLC prior notice to such disclosure and shall comply with any applicable protective order or equivalent.

Student Signature

Date

School Representative/Witness



Application Fee \$40 Non-Refundable

This is an agreement between Genesis Allied Health Services LLC and:

Student's Name _____ Telephone _____

Address _____

The school agrees to provide the following training:

Course Title _____

Start Date: _____ End Date: _____

Program consists of _____ weeks (x) _____ hours per week = _____ total hours.

Phlebotomy Technician Tuition \$ 950

Phlebotomy Tuition Down Payment..... (Due at Registration) \$400 (Due at registration) Non-refundable

Tuition Payment Due Week 1.....\$ 300

Tuition Payment Due Week 3.....\$ 250

Phlebotomy Technician Refresher \$675

Down Payment\$400

Final Payment.....\$275

Tuition includes Materials and supplies, and Course Completion Certificate (Textbook not included)

Clinical Medical Assistant Tuition \$ 1970

Clinical Medical Assistant Down Payment..... (Due at registration) Non-refundable) \$570

Every 2 -Weeks Tuition Payment\$350

Final Payment.....\$350

Patient Care Technician \$899

Down Payment.....\$499(Due at registration) Non-refundable

Bi-weekly Payments \$200

Final Payment.....\$200

Pharmacy Tech.....\$2500

Down Payment..... \$600 Due at registration) (Non-refundable)

Bi-weekly Payments.....\$350

Week Nine Payment..... \$250

Week Eleven Payment..... \$250

Home Health Aide (Hybrid)\$620

Down Payment\$370

Final Payment.....\$250

IV Tech.....\$375

"Trinity" Training Course (includes 3 Certifications in 1 course: Clinical Medical Assistant-Phlebotomy Technician-

ECG..... \$2260

Down Payment \$ 570

Bi-weekly Payments..... \$ 350

Final Payment.....\$290

If school pays for exam fees for the "Trinity" Courses the cost is \$2617

Exam fee not included in tuition – Student Pays Exam Fee \$119

Tuition includes Materials & Supplies, Blood Pressure Cuff & Stethoscope, (1) Uniform, Malpractice coverage while enrolled in the course. CPR is included in the tuition.

**Late fees applicable on missed payments. (1) day \$25 (3) Days \$50 and (7) Days \$100 (automatic drop)*

Agreement is Binding: This agreement will be binding only when it has been fully completed, signed, and dated by the student and an authorized representative of the school prior to the time instruction begins.

Changes in the Agreement: Any changes in the agreement will not be binding on either the student or the school unless such changes are acknowledged in writing by an authorized representative of the school and by the student or the student's parent or guardian if he/she is a minor.

Acceptance: I certify that I have read and understand the cancellation and refund policy and the complaint procedure; I have received a copy of the school catalog or brochure; and I am entitled to an exact copy of this Enrollment Agreement, school catalog, and any other papers I sign. **Cancellation of Classes:** The school reserves the right to cancel a course if the number of students enrolling is insufficient. Such a cancellation will be considered a rejection by the school and will entitle the student to a full refund of all money paid except the application fee.

Cancellation and Refund Policy for Resident Training Programs:

1. The school must refund all money paid if the applicant is not accepted. This includes instances where a starting class is canceled by the school. Application fees are non-refundable.
2. The school must refund all money paid if the applicant cancels within five business days (excluding Sundays and holidays) after the day the contract is signed, or an initial payment is made if the applicant has not begun training.
3. The school may retain an established registration fee equal to ten percent of the total tuition cost, or one hundred dollars, whichever is less, if the applicant cancels after the fifth business day after signing the contract or making an initial payment. A "registration fee" is any fee charged by a school to process student applications and establish a student record system. Furthermore, if supplies such as uniforms, equipment, interactive review test prep were issued, no refunds will be made for those materials.
4. If training is terminated after the student enters classes, the school may retain the registration fee established under (3) of this subsection, plus a percentage of the total tuition as described in the following table:

If the student completes this amount of training:	The school may keep this percentage of the tuition cost:
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One week or up to 10%, whichever is less	10%
More than one week or 10% whichever is less but less than 25%	25%
25% through 50%	50%
% 50% More than 50%	100%

When calculating refunds, the official date of a student’s termination is the last day of recorded attendance:

- (a) When the school receives notice of the student’s intention to discontinue the training program; or
- (b) When the student is terminated for a violation of a published school policy which provides for termination; or,
- (c) When a student, without notice, fails to attend classes for thirty calendar days. All refunds must be paid within thirty calendar days of the student’s official termination date.

Notice to Applicant:

Do not sign this agreement before you read it or if it contains any blank spaces. This is a legal document. All pages of this agreement are binding. Read both sides of all pages before signing. You are entitled to an exact copy of the agreement, school catalog, and any other papers you may sign and are required to sign a statement acknowledging receipt of those.

Cancellation of Contract: If you have not started training, you may cancel this contract by submitting written notice of such cancellation to the school at its address shown on the contract, which notice shall be submitted not later than midnight of the fifth business day (excluding Sundays and holidays) following your signing this contract or the written notice may be personally or otherwise delivered to the school within that time. In event of dispute over timely notice, the burden to prove service rests on the sender.

Unfair Business Practices: It is an unfair business practice for the school to sell, discount, or otherwise transfer this contract or promissory note without the signed written consent of the student or his/her parent or guardian if he/she is a minor and a written statement notifying all parties that the cancellation and refund policy continues to apply.

Clinicals/Externships:

Courses that require clinical rotation (Medical Assistant, Patient Care Tech, Pharmacy Tech, and Phlebotomy), the student will be responsible for finding a site to complete their externship hours. In the event that a student cannot find a clinical site, the school will assist and place the student wherever sites are available. Clinicals are mandatory for students at GAHS.

Student Name (Please Print) (Date)

Student Signature

Parent or Guardian Signature (Please Print)

Parent Signature (DATE)

As the authorized representative of the school, I hereby agree to the conditions set forth herein:

Authorized School Representative (Print Name)

Signature

Date
