Harborview School of Phlebotomy, LLC
141 captain Thomas Blvd.
West Haven, CT 06516
(475) 238-6678 Fax (475) 238-7950

Certified Nursing Assistant Program Registration Form
Any application sections left blank WILL DELAY program enrollment

REQUIRED Information:

Day Classes ☐ Evening Classes ☐ Start Date _____

First Name _____ Last Name _____

Name Previously Used _____ Check one: Male ☐ Female ☐

Social Security #_____ Date of Birth _____

Address _____

City _____ State _____ Zip code _____

Email Address _____

Home Phone _____ Cell Phone _____

Language Spoken _____ Secondary Language ☐ yes ☐no

Do you have a learning disability? ☐ Yes☐ No If yes, what type? _____

Hearing Impaired Yes ☐ No ☐ Any Services Needed _____

Visually Impaired Yes ☐ No ☐ Any Services Needed _____

How did you hear about our program? Friend/Relative ☐ Past Graduate ☐ website/online ☐ Billboard ☐ Community agency /Case worker ☐

Please list name/organization/source where you learned about our program: _____

EMERGENCY CONTACT : Name _____Relationship _____

Emergency Telephone: _____

DEMOGRAPHIC INFORMATION

Education: GED ☐ High School Diploma ☐ Vocational Training ☐ College Degree ☐

If you do NOT have a GED/High School Diploma List: Last Grade completed _____

High School Attended _____

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MILITARY HISTORY

Military Branch: _____

Military Service: Active-Duty ☐ Reserves ☐ Veterans ☐

Wounded Warrior (Check one, if applies) 9/11 to present Wounded ☐ Caregiver of wounded warrior ☐

Immediate family member ☐

WORK HISTORY:

Employment: _____ Are you currently employed? ☐ Yes ☐ No

If yes where? _____

City Where employed: _____ Full-time ☐ Part-time ☐

Have you ever worked as a Nursing assistant/Home health Aid before? ☐ Yes ☐No

If yes where did you work? _____What year? _____

JOB SEARCH (Information after Graduation)

Where are you interested in working? ☐ Hospital ☐ Lab ☐ Nursing Home ☐ Other

What shifts are you available to work? ☐ Mornings/Days ☐ Afternoon/Evenings Nights ☐ Weekends

What type of transportation do you have? ☐ Car ☐ Bus/Bus/line accessible ☐ Relative /friend

ESSAY:

In the space provided below, tell us why you want to join our program and begin a new career. (in 2-3 sentences)

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**** ANYONE CONVICTED OF A FELONY OR A CRIME CONSTITUTING A MISDEMEANOR ON THE FIRST OFFENCE AND A FELONY ON A SUBSEQUENT OFFENCE MAY HAVE A DIFFICULT TIME FINDING EMPLOYMENT IN A POSITION THAT PROVIDES DIRECT CARE TO ELDERLY ADULTS ****

CRIMINAL RECORD

Have you ever been convicted of a felony or misdemeanor? ☐ Yes ☐No Date of Charge _____

If yes. Please list the charges and explain.

Has a health-related licensing, certificate or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you? ☐ yes ☐ No Date of charge: _____

If yes, indicate the type and number of license/certificates: _____

I hereby acknowledge that my statements above are true and correct. I understand that false or inaccurate information will be the basis for termination from the phlebotomy program. I understand the Harborview School of Phlebotomy, LLC attendance and refund policy. If I indicated that I have been convicted of a disqualifying crime, I will not be eligible for employment as a caregiver in my state and not permitted to attend the Phlebotomy Technician Course. I authorize the Harborview School of Phlebotomy, LLC to release this application information and my complete program student file to my potential employers and other organizations that may offer scholarships for promising program candidates. My complete Harborview School of Phlebotomy, LLC, Phlebotomy Technician file, including grades, attendance records and all other course materials may be released to my funding source third party provider, caseworker, or potential employer, if requested

Enrollee/Student Signature _____ Date _____

Use the button below to submitt this form