



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/certificate: _____

I hereby acknowledge that my statements above are true and correct. I understand that false or inaccurate information will be 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 _____