MEDICATION AIDE COURSE PAYMENT PLAN CONTRACT

STUDENT NAME:_____
ADDRESS:_____
PHONE NUMBER:_____
EMAIL:_____

I, the registering medication aide student, agree to make payments on the specified dates and the agreed amounts stated on the payment schedule below, to Nursing Training Center. I agree to make my final payment by or on the 10th classroom day. I understand that I will be withdrawn from the Medication Aide course if final payments are not made by day 10 of class or if other arrangements for payment have not been agreed upon by this date. Students will receive a *W* and may be eligible to register for a future class once this class is paid off.

Total amount owed: $850 Deposit Required: $250

Payment Date	Payment Amount	Balance

I agree that the above schedule of payments is an acceptable resolution to help pay for my class, and I will remain current with this payment plan.

Student Signature_____Date:_____

Witness: Printed name_____

Witness: Signature_____Date:_____