# HCA APPLICATION

Print Name: _____

Date of Info Meeting You attended: _____

      Students must have a valid email address to register for the state test. If you do not have an email, we will help you set up a free email account. If you request a start date more than six months from today, you will need to attend another orientation.

Primary phone number: _____

Email address: _____

## **Print Clearly**

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| If you have been referred to us by an agency or facility such as Work source or your employer, please provide their contact information. |
| Employer/Case Manager Name: _____ Email: _____ |
| Facility/agency Name: _____ Phone number: _____ |

To fill out the DSHS BC authorization from online: https://fortress.wa.gov/dshs/bcs/

    10-digit BCCU confirmation number: _____

_____ (initial) By submitting this application, you are confirming that you do not have any convictions or negative actions which restrict you from working in this field.

Reminder:  You are responsibility for the Department of Health Application, which should be completed prior to the start of class.

Month you wish to start: _____

Preferred session: AM (9a-2p) _____ PM (4p-9p) _____