

# FAST TRACK MEDICAL TRAINING CENTER

Pavilion at Ocean Point & Rehabilitation Center

3202 Duke Street, San Diego. CA 92110

ftmedical888@yahoo.com

858-228-7564

## APPLICATION OF ADMISSION

### Nurse Aide Program

#### **Contact Information:**

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_

Driver's License: \_\_\_\_\_

State: \_\_\_\_\_

Email Address: \_\_\_\_\_

ZIP Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work: \_\_\_\_\_

#### **What hours can you attend classes?**

Weekdays: M \_\_\_ T \_\_\_ W \_\_\_ TH \_\_\_ F \_\_\_

Weekends: S \_\_\_ Sun \_\_\_

HOURS: \_\_\_\_\_

HOURS: \_\_\_\_\_

When can you begin your training?

Specific date: \_\_\_\_\_

#### **PERSONAL INFORMATION**

Gender: \_\_\_\_\_

Married Status: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Are you a U.S. Citizen? Y\_\_\_N\_\_\_ Resident Card: Y\_\_\_ N\_\_\_ If NO, explain: \_\_\_\_\_

Minor traffic violation like DUI/ major accident, child support or convicted of a crime? Y\_N—

If YES: Talk to me HELEN SCHMIED Program Director privately.

#### **EMERGENCY CONTACT**

Name and relationship: \_\_\_\_\_

Contact: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

***I certify that all information provided on this Application is true and correct.***

**Signature of Applicant:**

**Date:**