ASHONA MEDICAL INSTITUTE

Pioneers in Allied Healthcare Education

1315 Milstead Road, Conyers, GA 30012

* Phone: 770 922.6913 * Fax: 770 7608764

Student File Checklist

Tick Program of Interest: **Nursing Assistant** **Phlebotomy** **Medical Care Assistant (CNA)**

Patient Care Technician with CNA **Patient Care Technician** **Polysomnographic Technologist (Sleep Technologist)**

Financial Records

- **Tuition Invoice(s)**

Admissions Application

Copy of High School Diploma or GED Equivalent

Copy of I.D. /Social Security Cards

Enrollment Agreement Form

Placement Disclosure Form

Confidentiality Statement

Photo Permission Form

Medical Form & All Supporting Documents

TB Skin Test Results

Health Disclaimer Form

Emergency Notification Form

Academic Transcripts

Attendance Records

Progress report or correspondence

Evaluation for externships or internal clinical experience

Documentation of placement activity

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Application for Admission

Tick Program of Interest

Nursing Assistant **Phlebotomy** **Patient Care Technician with CNA**

Patient Care Technician **Polysomnographic Technologist (Sleep Technologist)** **CNA**

Date: ___________________

Name (First, Middle, Last): ____ DOB: _______________
(mm/dd/yyyy)

Street Address: ____

City: ________________________ State: _________________ Zip: ___________________________

Phone: ___________________ Email Address: ____

Are you a U.S. Citizen? _____________ If no, what is your citizenship? _________________________

Do you have any personal, physical, or mental limitation(s) requiring accommodations by the school?
__________ if yes, please explain: ____

Have you ever been convicted of a crime? _______ if yes please explain_________________________

____

In the event of an emergency, whom should we contact? Please provide Name and Number:
____

How did you hear about our School? ____

Medical Program preferred ____

Method of Tuition Payment: ____

U.S. MILITARY SERVICE (if applicable)

Date Entered: __________________________ Highest Rank Held: _________________________

Date Discharged: ________________________ Rank at Discharge: __________________________

Are you a member of Active Reserves? ______ If yes, what is your obligation? _______________________

____

TRANSPORTATION

Do you have a valid driver's license? **Yes** **No**

EDUCATION

School Type	Name and Location	Major	Graduate	Dates Attended
High School				
College or Other Schooling				
College or Other Schooling				

Grade Point Average: High School ______________________________ College: ______________________________

If you were not a graduate of the last you attended, why did you leave school? ________________________________

List any additional special training, certifications, or licenses you have acquired: _______________________________

____

DISCRIMINATION POLICY

Ashona Medical Institute is committed to equal educational opportunities. We do not discriminate against students on any legally recognized basis including, but not limited to veteran status, race, color, religion, sex, and National origin, physical or mental disability, or age. In addition, age and disability are protected classes in Georgia.

We are committed to providing equal educational opportunities to qualified individuals with disabilities. This may include providing reasonable accommodation where appropriate. It is the student's responsibility to notify the Director of Admissions regarding the need for an accommodation. Upon doing so, the Director of Admissions may ask for the student's input on the type of accommodation that may be necessary. When appropriate, we may need the student's permission to obtain additional information from a physician and other medical of rehabilitation professionals.

ACCEPTANCE

I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that if accepted, falsified statements on this application shall be grounds for immediate dismissal.

Student's Signature ____ Date ____________________

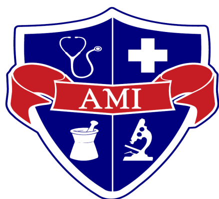
ADMISSIONS OFFICE USE ONLY

Accepted

Not Accepted

Director of Admissions ____ Date ________________________

School Administrator____ Date ________________________



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ENROLLMENT AGREEMENT

Student Full Name ____ SSN __________________ DOB _______________

Street Address, City, State & Zip: ____

Home Phone ______________________ Work Phone ________________________ Cell ________________________

PROGRAM: ____Patient Care Technician_________________ Hours: _______ Credentials awarded: certificate________

Scheduled Days per Week: __Monday - Thursday_____________ Number of Hours per Week: _____________________

Total Number of Credits to be Completed: ______________ Total Number of Weeks to be Completed: ____________________

Program Length: ____________ Day Class: __________ Evening Class: __________ Weekend Class: ___________________

Start Date _________________________________ Scheduled Completion Date ______________________________

TOTAL FEES, CHARGES AND EXPENSES: COVERING THE PERIOD FROM____________TO_________________

Registration Fee	$ ________________	this fee is nonrefundable
Tuition	$ ________________	
TOTAL CHARGES	$ ________________	
Less Dedct / Misc Charge/ Bk	$ (_______________)	______________________________
BALANCE DUE	$ ________________	YOU are responsible for this amount. If you get a student loan, YOU are responsible for repaying the loan amount PLUS any interest.

Balance to be paid (weekly/bi-weekly/monthly): ____

Students are required to purchase their books prior to the first day of class. Information will be provided as to that book(s) to purchase. The book(s) can range from $5 to $300.

REQUIREMENTS FOR SUCCESSFUL COMPLETION
As outlined in the catalog, the student is required to meet and maintain the Institute's established standards for academic progress.

PLACEMENT ASSISTANCE
As outlined in the catalog, students are offered Job Placement Assistance upon completion. Entering this agreement does not provide a guarantee for employment placement upon completion.

NON DISCRIMINATION
Ashona Medical Institute does not discriminate on the basis of race, color, creed, religion, national origin, ancestry, sex, age, sexual orientation, or disability in the administration of any of its educational programs or activities.

STUDENTS RIGHT TO CANCEL
You, the student, may cancel your enrollment without penalty or obligation at any time prior to midnight of the third business day after signing this enrollment agreement. You may cancel your enrollment, if upon a Doctor's order, you cannot physically receive the services, or you may cancel your enrollment if the service ceases to be offered by the Institute. Please refer to the **REFUND POLICY** for further information.

FINANCIAL OBLIGATIONS

The student must maintain good financial standing. The student is expected to make payments in accordance with the payment agreement entered at the time of enrollment. There shall be no exceptions. If the student should fail to make payment(s) as agreed upon and/or should Ashona Medical Institute prevails in a lawsuit to collect monies owed, the student agrees and understands that he/she is responsible for all court costs to include attorney fees in the amount the court finds to be reasonable. The Student agrees and understands that uncollected debt will be reported to all credit bureaus. The Student agrees and understands that should there be an outstanding debt owed, **Ashona Medical Institute** reserves the right to remove the student from the program and/or final exams.

Student Signature	Student Name	Date
Parent/Guardian Signature	Parent/Guardian Name	Date

REFUND POLICY

All monies paid by the prospective student, with the exception of the application fee, will be refunded upon written request within three (3) business days after signing the enrollment agreement. For an applicant requesting refunds more than three (3) business days after signing the enrollment agreement or for a student completing no more than 5% of the instructional time, 95% of the tuition will be refunded. For a student completing 5%, but no more than 10% of instructional time, 90% of the tuition will be refunded. For a student completing 10%, but no more than 25% of instructional time, 75% of the tuition will be refunded. For a student completing 25%, but no more than 50% of instructional time, 50% of the tuition will be refunded. For student's completing more than 50% of instructional time, the institute will retain 100% of the tuition.

STUDENT ACKNOWLEDGEMENT

I have read a copy of **Ashona Medical Institute** current catalog; the provisions of which I accept. I have read and understand all of the provisions of this enrollment agreement and I have been given a copy for my records. I understand that my enrollment and obligations under this agreement (excluding cancellation & refund) may be terminated if I fail to comply with the Institute's attendance, academic, financial and/or other requirements. I understand that **Ashona Medical Institute** reserves the right to cancel my enrollment if it is determined that I do not meet my financial obligations related to enrollment and continuing enrollment. I understand that my financial obligations must be met in full before a certificate will be awarded and transcripts will be issued.

This agreement is a legally binding instrument when signed by me and accepted by the institute. I have received a copy of the School's catalog. Having read and understand the contents of this Enrollment Agreement and the Financial Obligation section of this Enrollment Agreement and intending to be legally bound by it, I agree to abide by the School's rules and regulations as stated in the catalog.

My signature below certifies that I have read, understood and agreed to my rights and responsibilities, and the institution's cancellation and refund policies have been clearly explained to me.

Student Signature	Student Name (Please Print)	Date
Parent/Guardian Signature	Parent/Guardian Name (Please Print)	Date
	Sheweguta Z. Mukahanana	
School Administrator's Signature	School Administrator's Name (Please Print)	Date

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Placement Disclosure Form

Ashona Medical Institute provides Job Assistance to graduates. **The school cannot and does not promise or guarantee employment upon graduation.**
Assistance will be provided in the form of some or all of:

- Interviewing Skills
- Resume Preparation
- Job Search Techniques
- Scheduling Interviews

In the medical field, many jobs start part-time, averaging 16-24 hours per week, with an opportunity to progress to or change employment to a job that is full-time. Approximately one-half of the students who are employed after graduating from our facility, start out part-time. Some remain part-time and some move to full-time positions.
I understand that finding employment is a joint effort between the school and me. I agree to cooperate with Career Services and/or school staff in conducting my job search including providing 20 copies of my resume on time, participating in scheduled workshops, attending interviews and completing all required assignments. Furthermore, I understand that the full-time effort it takes in finding a job upon completion of the program is similar to that of completing the program itself. I will commit myself to a reasonable period in conducting my job search process, which could be 3 to 6 months or longer.
I understand that a potential employer will consider attitude, grades, and personal performance on an interview, work background, education background, and other intangible factors in determining employment.
I have not been promised employment or any specific starting salary by any representative of Ashona Medical Institute.

______________________________________ _____________________________

Student Signature **Date**

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CONFIDENTIALITY STATEMENT

As a student of Ashona Medical Institute I am aware of my responsibility to maintain the confidentiality of any/and all information which I may come in contact with and/or have access to while in training, in the classroom and while on clinical. ***I am also aware that I am responsible for the legal penalties, which may be assessed for unauthorized disclosure***.

Signed: ____

Student signature

Print Name: ____

Student name

Date:______________________

School Representative: ____

Date: _________________________

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PERMISSION TO USE PHOTO & NAME

I, ____, give my permission to Ashona Medical Institute to mention my name and/or submit my photograph in:

(Please check the areas that you give permission.)

__________1. School newsletter (picture or name)

__________2. School bulletin board (picture or name)

__________3. Newspaper article featuring the school (name)

__________4. Honor Roll (name)

__________5. Student recognition (picture or name)

__________6. Picture or class picture in local newspaper

__________7. School web site (picture or name)

__________8. All of the above

Comments: ____

____

Date: __________________________

Signature: ____

School representative: ____

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HEALTH DATA FORM/ TB SKIN TEST RESULTS

Class Start Date: _____/____/______ ***Program:*** ____________________________________

Campus: Conyers

Student Name: ____

Social Security Number: ____________________ Date of Birth: _____/_____/______

The clinical site that you will be assigned to requires Tuberculosis (PPD) test/TB skin test before starting clinical. The Student is responsible for obtaining this test prior to starting clinical. If the student has had a PPD within the last 12 months, the school will accept a copy of the results.

Note: Depending on the requirement of your clinical site, a complete physical may be required. The Student will be responsible for the cost of the physical.

DO NOT WRITE BELOW THIS LINE-FOR OFFICE USE ONLY

DATE: ______________________

PPD administered by: ____

Location: _______________________________________**Date:**____________________

PPD Read by: ___________________________________**Date:**____________________

Results: ___________________________ **Chest X-Ray Required: Yes**______ **No**______

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HEALTH DISCLAIMER FORM

STUDENT NAME (PLEASE PRINT) ___________________________________

START DATE: _____________________________

I, ____am in good physical and mental health, to the best of my knowledge I have no handicaps or emotional conditions that may affect my training at **Ashona Medical Institute** and/or my clinical externship.

PLEASE COMPLETE ON OF THE FOLLOWING:

I, ____am NOT PREGNANT and will notify **Ashona Medical Institute** should I become pregnant during the training period.

OR

I,____ AM PREGNANT and have attached a copy of my physical examination by an OB/GYN physician stating that this training will not affect my pregnancy and that I am in good physical condition and able to perform the job to which I may be assigned.

SIGNATURE: ____

DATE: _______________________________

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HEPATITS B VACCINE WAIVER

This form will be included in you student medical record.

I understand that as a student in a health program I have an increased risk of contracting this serious illness and that it can be prevented by Hepatitis vaccine.

Check one:

______ I plan to seek immunization through my private Doctor or by a health care facility and I will provide a copy of my verification.

______ I am already immunized. I will provide verification.

______ I have decided not to pursue immunization for Hepatitis B while enrolled in school, even though I understand I am at some risk of contracting this disease. Therefore, by signing this form I am waiving any rights I may have against the school and am hereby releasing Ashona Medical Institute from any responsibility should I be exposed or possibly contract Hepatitis B

Date: ________________

Signature: ____

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EMERGENCY NOTIFICATION FORM

DATE: ________________

In case of emergency, please contact:

Name: ____Relationship_________________________

Address: ____

City: ____***State:*** ________________***Zip:***________________

Telephone: (   ) ____