

Professional Healthcare Educators

1286 Kalani St. B-204, Honolulu, Hawaii 96817 / Tel:(808)847-3366

PHLEBOTOMY CLASS APPLICATION FORM

Note: We reserved the right to schedule a scheduled class if less than 4 students



~~Ref~~rolled. Once a deposit/payment is received, no refund is allowed.

This Enrollment/agreement, is between the above named school and:

LAST NAME: _____ FIRST: _____ MI _____

Address: _____ City: _____ Zip Code: _____

Cel Phone: () _____ Photo ID ___ Last 4 digit of SS# _____

We may ask: how did you find us? Newspaper: ___ Friend/Family: ___ Internet: ___

Email address: _____

School Location: Honolulu ___ Waipahu ___ AM ___ PM ___ Class Date: _____

Hybrid (online+classroom for skills, 8-9days)

The school agrees to provide the following training:

Course or program title: **PHLEBOTOMY CLASS/TRAINING**

Tuition Fee: \$1150.00+\$46.00 (tax)=\$1196.00

Training /class includes:

- ❖ Book
- ❖ Uniform
- ❖ Supplies/Materials

We need TB Clearance, Proof of Vaccine or test results within 2 days prior to your clinical schedule

Less: Registration fee (Initial Payment).....\$400.00* **(Non-refundable)**

Signature: _____ (Acknowledging the \$400.00 non-refundable)

Debit or credit card 6% surcharge will be added.

Agreement is binding:

This agreement will be binding only when it has been fully completed, signed and dated by the student and an authorized representative of the school prior to the time instruction begins.

Drop Policy Charge: Refund Charge For cancellations up to:

*If an applicant has put down more than the required \$400.00 deposit he/she is eligible to obtain a refund as long as he/she has turned in a REFUND REQUEST FORM prior to 10 (ten) working days before the start of the class initially applied for \$20.00 will be assessed as a processing fee.

100% Day of Class or thereafter- No Refund

Full Refund if class is cancelled

Effective date of acceptance:

I hereby agree to abide by the conditions set forth herein. I declare that I am 18 years of age or older, a high school graduate or equivalent, and of no criminal record.

Print Name _____ Sign _____ Date _____

School representative _____ Date _____

For office use only: Book ___ CPR/FA: ___ Uniform: ___ TB Clearance: ___ Vaccine : _____

By: _____ Date: _____

Deposit: _____ Balance: _____ Date Paid: _____