BLAKE EDUCATIONAL CENTER
HOME HEALTH AGENCY

PERSONAL CARE ATTENDANT CERTIFICATION COURSE

REGISTRATION FORM

Student Name: _____ Date: _____

D.O.B. _____ S.S.N _____ - ____ - _____

Phone (home): (____) _____ - _____ Phone (mobile) (____) _____ - _____

Email Address: _____ Male ____ Female _____

Address: _____

Street *city* *state* *zip*

Emergency Contact: _____ _____

Name/ relationship *Phone*

Previous Education: _____ _____

Name of School/ Institution *Year attended*

Current Employment: _____ _____

Name *Length of time*

By signing below I acknowledge that I am responsible for the full tuition amount for this course. I understand that certification will not be awarded and I will not be allowed to take the final exam unless all outstanding fees are paid in full. Payment in full does not guarantee an awarded certificate but my attendance, participation and examination results will be considered in determining my final score for this course.

_____ _____

Signature *Date*

Office Use Only

*Final payment made for the balance of the course registration fee are required prior to taking the final exam. Accepted forms of payment: Money orders, cashier's checks, Cash

Class Start Date: _____ **Student Classification:** ____ EDCD Transfer ____ Enrolled Student

Registration Fee (for enrolled students only) : $____ Pd Date _____

1st Payment $_____ Date _____ **2nd Payment**_____ Date_____

CPR Certification: $ _____ Date_____ **EDCD Transfer Copy Fee**: $____ Date _____

EDCD Transfer employees must be with agency for a minimum of one year in order to receive a copy of their certification or pay the current course registration fee. After 1 year there is a $50 fee for a copy of certification.