



MEDICATION AIDE REGISTRATION FORM

Name: _____
Last First

Address: _____

Telephone: Home (____) ____ ____ Cell: (____) ____ ____

Fee: _____ Amount Enclosed: _____

- A. Have you completed a Nursing Assistant Course? Yes No (If yes, please attach copy of certificate or License). **OR**
B. Have you completed a Direct Care Staff Training? Yes No (If yes, please attach copy of certificate).

We Accept: Master/Visa/Amex/Discover. Please circle the type of card you will be paying with.

Credit Card #: _____ **Exp Date:** _____

Name on credit card: _____ **Zip Code:** _____

Security Code: _____

Signature: _____ **Date:** _____

**Please return registration form and deposit in the amount of \$75.00 to: Standard Health Care,
P. O. Box 9164, Reston, VA 20190.**

To secure a space in the class, a deposit of \$75 (seventy five dollars), in check or money order payable to **Standard Health Care Inc.**, must be received three days prior to the first day of class. Cancellation Made three days prior to the start date of class will be fully refunded.

Payment plan is available.