Hawaii Institute of Healthcare & Training Services (HIHTS)

Professional Training Program
1059 Kilauea Ave.
Hilo, Hawaii 96720
Tel.: (808) 933-1295 or (808) 933-1266 Fax: (808) 933-2722
Email: hihts@live.com Website: www.hihts.us

APPLICATION FOR MEDICAL ADMINISTRATIVE ASSISTANT TRAINING

Name: _____ Social Security No.: _____
Address: _____ Phone: (Residence): _____
_____ (Cell)_____ (Work)_____

Email (please print)_____
Are you 18 years age or older? [ ]Yes [ ]No
What languages do you speak? _____
U.S. Citizen? [ ]Yes [ ]No Alien/Green Card? [ ] Yes [ ] No Alien Card #:_____

How did you hear about Hawaii Institute of Healthcare and Training Services?_____

Have you ever been convicted of a crime or had traffic violation(s) by any court? [ ] Yes [ ] No
(If Yes, please explain nature of the incident and current status) _____
_____
If applicable, will you be able to provide letters from your probation officer? _____
If Applicable, will you be able to provide at least three (3) letters of recommendation? _____

Emergency Contact Person: _____ Phone: _____
Address: _____

SCHOLARSHIP INFORMATION (If applicable)

Course Code	Cost	Course Title	Date(s)	Time

Company/Agency Name: _____ Contact Person: _____
Address: _____ Phone: _____
_____ Fax: _____
Covered Cost _____

FOR OFFICE USE ONLY

Registration No.: _____ **Acct. No.** _____ **Initial:** _____

NON-REFUNDABLE PRE –REGISTRATION FEE: $250.00

TO REGISTER PLEASE CALL: 933-1295

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STUDENT AGREEMENT

I, _____(student name), agree to release and hold harmless Hawaii Institute and Healthcare & Training Services, its staff and clients, who provides my training and clinical practice from any accidents or misconduct that arises during the period of my training.

I certify that all statements made here on this application are true to my knowledge and agree to pay all tuition costs.

_____ _____
Student's Name (printed) Date

_____ _____
Student Signature Date

I give consent to use any video or photography on HIHTS website to promote any and all classes. (If signature is not provided, consent is not given)

_____ _____
Student's signature over printed name Date

Hawaii Institute Healthcare & Training Services
Medical Billing Training Program

1059 Kilauea Ave.
Hilo, Hawaii 96720

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Fax: (808) 933-2722
www.hihts.us

STUDENT NAME: _____

ADMISSION REQUIREMENTS: (can be obtained throughout the course time)

- Completed application form
- Pre-Screening Test complete, Passing
- Eighteen (18) years of age or older
- High school graduate or G E D
- Computer Literate

OTHER REQUIREMENTS:

1. Scrub uniform
2. White Shoes
3. Notebook/Pen/Pencil

SCHEDULE OF CHARGES:
$250.00 Non-Refundable Pre-Registration
$322.50 1st Week of Class
$322.50 2nd Week of Class
Total cost $895.00
TUITION DISCLAIMER:
Failure to pay may result in cancellation of registration or suspension of class. Only cash, checks, and credit cards are accepted. Checks payable to: **Hawaii Institute Healthcare & Training Services (HIHTS.)**

Signature of Student: _____ Date: _____