SCR Health Care Academy Application

Enrollment application

Applicant Information

- Full Name: _____
- Date of Birth: _____
- Social Security Number (SS#): _____
- Address: _____
- Phone Number: _____
- Email Address: _____

Program Selection

Check the program you are applying for:

- [ ] State Tested Nursing Assistant (STNA)
- [ ] Home Health Aide (HHA)
- [ ] Phlebotomy
- [ ] Medication Aide (Coming Soon)

Educational Background

- High School Attended: _____
- Year Graduated: _____

College Attended: _____

Year Graduated: _____

Degree Earned: _____

Employment History

Please provide details of your last three places of employment:

- Employer Name: _____

- Position Held: _____
- Dates of Employment: _____
- Responsibilities: _____
- Employer Name: _____
- Position Held: _____
- Dates of Employment: _____
- Responsibilities: _____

References

- Name: _____
- Phone Number: _____
- Relationship: _____
- Name: _____
- Phone Number: _____
- Relationship: _____

Emergency Contact

- Full Name: _____
- Phone Number: _____
- Relationship: _____

Statement of Understanding

I certify that the information provided is accurate to the best of my knowledge. I understand that a background check is required for admission and that providing false information may result in rejection or dismissal.

Applicant Signature: _____

- Date: _____

For Office Use Only

- Application Received By: _____
- Date Received: _____
- Application Status: Approved [ ] Denied [ ]