**Certified Nurse Assistant**

Date of Deposit/Payment:_____

Student Copy Received: _____/_____


205 2nd Street NW, Cleveland, TN 37311
423-614-3838

# STUDENT ENROLLMENT AGREEMENT

## Student Information

**Name**: _____,_____
Last First Middle

**Address**: _____
Street City State Zip Code

**Social Security #** _____ - _____ - _____ (***required*** for certifications/state registries)

**Telephone**: Primary: (_____)_____ Alternate: (_____)_____

**Email Address**: _____ **Date of Birth** ____ / _____ / _____

How did you hear about Matrix Medical Training Center? _____

Are you 18 years of age or older? ☐ Yes ☐ No
**If no, a parental signature **must** accompany each area below a student's signature.*

One of the following is **MANDATORY** for your student file:

**Please select which applies to your situation:**

- ☐ OFFICIAL High School Transcripts
- ☐ OFFICIAL GED Scorecard
- ☐ Passing ATB Test Score of _____

**Have you ever been diagnosed with a learning disability or have you ever been assigned an IEP or 504 plan in school?** ☐ Yes ☐ No

**This does not determine acceptance, but allows us to provide as much help to every student as possible.*

**Required Information**

Gender: ☐ F ☐ M

Height: _____ ft _____ in

Eye Color: _____

Race:
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Hispanic
- ☐ Pacifica Islander
- ☐ Asian
- ☐ American Indian/Alaskan
- ☐ Other _____

## Program Information

Program Title: **CERTIFIED NURSING ASSISTANT** Clock Hours: 90

Class Schedule: ☐ Day Class (FT) ☐ Evening Class (PT)

Starting Date: _____

Anticipated Ending Date: _____

## Tuition and Financial Arrangements

| | | |
|---|---|---|
| Tuition Cost | $ 595.00 | **Total Course Fee** |
| Registration Fee & Book Fee (*$100 non-refundable*) | $ 142.00 | |
| Uniform Fee (1 set of royal blue scrubs) | $ 40.00 | **$ 875.00** |
| State Certification Test Fee | $ 98.00 | |

Tuition and/or deposit may be paid by CASH, CHECK or CREDIT CARD.

| EVENING CLASSES | | DAY CLASSES | |
|---|---|---|---|
| ___ Paid in Full | $ 875 at registration | ___ Paid in Full | $ 875 at registration |
| ___ Payment Plan* | $ 275.00 deposit at registration<br>$ 200.00 by the end of second week<br>$ 200.00 by the end of fourth week<br>$ 200.00 by the end of sixth week | ___ Payment Plan* | $ 450.00 deposit at registration<br>$ 425.00 by the end of second week |

**A payment plan agreement must be signed upon registration and will be adhered to until completed*

In addition to tuition costs, each student is responsible for the following **before** clinical rotations and may incur additional costs:

- Watch (with an ability to count in seconds)
- Solid White Shoes (OSHA approved for the clinical environment)

## Refunds, Cancellations

1. Cancellations must be in writing on our official withdrawal form in order to be eligible for any refunded money, if a refund is constituted under our refund policy.
2. All monies will be refunded if the school does not accept the applicant or if the student cancels within (3) three business days after signing the Enrollment Agreement and making initial payment. However, refunds are not instant and will need processing time. A check will be mailed at a later date, within 30 days, according to the policy outlined in our catalog.
3. Cancellation after the third (3rd) business day, but before the first class day, will result in a refund of all tuition paid - with the exception of the registration fee which is non-refundable, as stated in the catalog.
4. Cancellation after attendance has begun will result in the following refunds:
   A. Day of 1st or 2nd class session = will result in a refund of 75% of the tuition, if paid in full, and loss of registration fee. If tuition is set up on a payment plan, the student is not eligible for any refunds after attending any class sessions.
   B. Day of 3rd – 4th class session = will result in a refund of 25% of the tuition, if paid in full, and loss of registration fee. If tuition is set up on a payment plan, the student is not eligible for any refunds after attending any class sessions.
   C. Cancellation after attending the 4th class session of the program will result in no refund.
5. A student can be dismissed, at the discretion of the Director, for insufficient progress, nonpayment of costs, or failure to comply with the rules or code of conduct.
6. Those wishing to postpone a scheduled course for illness, of themselves or an immediate family member, may resume their course of study in the next available class series with no penalty. The student may repeat the already completed sessions, if desired, at no additional charge or may pick up where they left off. Physician's

documentation is required for this circumstance. This is effective for extenuating health circumstances only. Employment, schedule conflicts or personal emergencies are not a valid reason for postponement.

7. For any program or course that is cancelled by the institution, the institution will refund the tuition in full or apply the tuition to a future course, depending on the wishes of the student and availability of courses.

## Course Requirements/Materials

Student is responsible for the following **before** the 1st day of class:

- **TB TEST RESULTS** – proof of negative reaction or a negative chest x-ray within the past 12 months
- **HEALTH EVALUATION FORM** – available in the Matrix office or on the website
- **HEPATITIS B VACCINE** – can provide proof that you have started/completed the series of Hepatitis B Vaccines and/or sign the Hepatitis B Vaccine Advisory Waiver
- **OFFICIAL HIGH SCHOOL TRANSCRIPTS** or **OFFICIAL COPY OF A GED SCORECARD** (Copies of diplomas, equivalency certificates, and unofficial copies cannot be accepted. An **official** copy must be mailed to our facility or a sealed version delivered in person. Faxed copies do not constitute as "official".)

Student is responsible for the following **before** Clinical Training:

- White Shoes
- Watch with a second hand

***Optional*** **Materials**

- Stethoscope
- Blood Pressure Cuff

**CELL PHONE POLICY**

Cell phone interruptions during class will not be tolerated. You must come to class prepared – meaning your cell phone is on silent or vibrate.

**NO CELL PHONES ARE PERMITTED INSIDE FACILITIES HOSTING CLINICALS.**
**NO EXCEPTIONS!**

## Current Employment

**We will **not** contact your employer for references or verification!*

***This information is kept confidential and is for state reporting purposes only – PLEASE COMPLETE!***

Are you currently employed: ☐ Yes ☐ No

If so, where? _____

Address: _____

# BACKGROUND HISTORY QUESTIONNAIRE

1. Have you ever been convicted of a criminal offense, whether a misdemeanor or felony (other than minor traffic violations)?
   If yes, please explain – using additional paper if necessary.

_____

_____

_____

2. Have you ever been convicted of abuse or neglect of another person in your care?
   If yes, please explain – using additional paper if necessary.

_____

3. Please list any states, other than your current residence, that you have lived in within the past 7 years.

_____

_____

By signing this questionnaire, I understand that I must answer these questions as honestly and completely as possible. **ANY** criminal history could forfeit the ability of becoming a healthcare professional and, even if capable, could result in difficulty locating employment because of such a background.
I also understand that I am subject to a full criminal background check at any given time while a student with Matrix Medical Training Center, LLC. The signature below also grants permission for my name to be searched on the required registries, including the abuse registry and sexual offender registries.

If convictions are found to be on a student's record, in which the student neglected to inform Matrix MTC of, the student is subject to immediate dismissal and inability to complete the course on the basis of dishonesty and/or ineligibility of the career choice. If termination is necessary, any money paid toward the course cost will be forfeited.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (only if student is under 18) Date

# Substance Abuse & Weapons Policy

This policy statement is to inform you that, as a student of this facility, you may be subject to a rapid-result, random drug screening at the discretion of the Facility Director at any given time during the course. Your signature below serves as an agreement to this policy.

If tested positive under any substance, an additional drug test by blood sample must be completed and proved negative before the student would be allowed to return to Matrix Medical Training Center. The blood test will be at the expense of the student, if needed.
If the blood sample drug screening results in a positive for prescription medications, the student would have to have physician documentation of the prescribed drug in their system and a statement from the physician that he/she does not believe the medication would prevent the student from reasonably being able to complete their duties for the job they are training for. Any absences related to these circumstances would be considered unexcused and, if excessive, could result in dismissal from the program due to insufficient attendance.

In addition, firearms, knives or any other items that could potentially be used as a weapon are not permitted inside this facility. Under no circumstances will it be acceptable to be in possession of anything that would make another student or staff member feel unsafe or threatened.

Refusal to comply with these policies may result in your immediate termination from the program. Upon dismissal, all money paid toward course costs will be forfeited under the circumstances of failure to abide by the facility's policy.

By signing below, I acknowledge that I have read, understand and agree to abide by this policy.

_____
Student Name

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (only if student is under 18) Date

# Bloodborne Pathogen and Post-Exposure Management
# Student Waiver

This waiver ensures that students understand that they, as part of their academic program, are at risk for exposure to human blood or other potentially infectious bodily material and acknowledge that the inherent risk of injury and illness is assumed by the student when they enroll for the academic program.

As part of the training program, you will learn about the bloodborne pathogens, Standard Precautions and what it means to protect yourself from potentially infectious materials. These guidelines will help you to understand the transmission of bloodborne infections and the hazards this profession poses.

As a student of Matrix Medical Training Center, I voluntarily assume all risks associated with my participation in this academic program. I agree to hold harmless, indemnify, and irrevocably and unconditionally release Matrix Medical Training Center, its officers, employees and agents, *as well as* the clinical rotation facility, its trustees, officers, employees and agents, from any and all liability and medical expenses, as well as any and all claims, causes of action or demands of any kind or nature, which may arise by or in connection with my participation in activities related to bloodborne pathogen exposure.

I understand that I may be asked to perform tasks that may pose a risk of exposure to bloodborne pathogens, which can cause diseases such as HIV and hepatitis that can lead to serious illness and death. Accidental exposure to blood or other potentially infectious material (OPIM) must be reported immediately to the appropriate personnel, which would be a facility instructor. I understand the post-exposure follow-up recommendations from the Centers for Disease Control and Prevention (CDC). Under these guidelines, I am advised to seek treatment and obtain a risk evaluation, which may include laboratory analysis, and if deemed necessary, initiate post-exposure prophylaxis (PEP). The CDC specifically recommends that PEP be initiated with two hours of exposure to prevent HIV transmission.

I understand that I am personally responsible for all of the costs associated with the post-exposure medical management/treatment and that Matrix Medical Training Center *nor* the affiliated clinical rotation facility is responsible for these expenses or for any injuries or illness that occur as a result of my participation.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (only if student is under 18) Date

# Hepatitis B Vaccination Advisory

I understand that due to my risk of occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B Virus (HBV). I am highly encouraged to receive the Hepatitis B vaccination, if not previously vaccinated. I understand the cost of the vaccinations, at this time, would be my responsibility. I also understand that if I decline the Hepatitis B vaccination, I continue to be at risk of acquiring Hepatitis B, a serious chronic disease that has no cure.
If previous vaccination has not taken place, I understand it is preferable to start the round of the three injections to maintain optimal health, prior to my risk of exposure.

_____
Student (Print Name)

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (only if student is under 18) Date

# TRANSFERABILITY OF CREDITS DISCLOSURE

***Matrix Medical Training Center offers CERTIFICATE programs that DO NOT award "credits" for individual subject matters taught within the course.**

Credits earned at *Matrix Medical Training Center* may not transfer to another educational institution. Credits earned at another educational institution may not be accepted by *Matrix Medical Training Center*. You should obtain confirmation that *Matrix Medical Training Center* will accept any credits you have earned at another educational institution before you execute an enrollment contract or agreement. You should also contact any educational institutions that you may want to transfer credits earned at *Matrix Medical Training Center* to determine if such institutions will accept credits earned at *Matrix Medical Training Center* prior to executing an enrollment contract or agreement. The ability to transfer credits from *Matrix Medical Training Center* to another educational institutions may be very limited. Your credits may not transfer and you may have to repeat courses previously taken at *Matrix Medical Training Center* if you enroll in another educational institution. You should never assume that credits will transfer to or from any educational institution. It is highly recommended and you are advised to make certain that you know the transfer of credit policy of *Matrix Medical Training Center* and of any other educational institutions you may in the future want to transfer the credits earned at *Matrix Medical Training Center* before you execute an enrollment contract or agreement.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (only if student is under 18) Date

# Emergency Contact Information

**Student Name**:_____
Last First Middle

**Insurance Information:**

Company: _____

Preferred area hospital:_____

**Emergency Contact Name:**_____
First Last

Relationship: _____

Cell Phone: (____) _____ Home Phone: (____) _____

Work Phone: (____) _____

**(2nd) Contact Name:**_____
First Last

Relationship: _____

Cell Phone: (____) _____ Home Phone: (____) _____

Work Phone: (____) _____

**Comments:** *Include any special medical or personal information (i.e. – medical conditions, allergies, etc.) that an emergency care provider would need to know – or any other specific information. (Please use reverse side of form if additional space is needed)*

_____

_____

I give permission to the staff of Matrix Medical Training Center to provide immediate first aid and/or contact emergency medical professionals, if needed, in any emergency medical situation while on the Matrix MTC premises or in clinical rotations off-site. I will not hold Matrix Medical Training Center or any member of the MMTC staff responsible for any adverse reactions of any first aid measures given for a warranted situation. I also understand that should EMS be needed, it will be my financial responsibility to cover the costs of services.

Student Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____
(Only if student is under 18)