



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**)

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 ABT Score of _____

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

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

Program Information

Program Title: **Phlebotomy Technician** Clock Hours: 80 (part-time)

Class Schedule: Evening Class Day Class

Starting Date: _____

Anticipated Ending Date: _____

Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Height: _____ ft _____ in
Eye Color: _____
Race:
<input type="checkbox"/> White/Caucasian
<input type="checkbox"/> Black/African American
<input type="checkbox"/> Hispanic
<input type="checkbox"/> Pacifica Islander
<input type="checkbox"/> Asian
<input type="checkbox"/> American Indian/Alaskan
<input type="checkbox"/> Other

Tuition and Financial Arrangements

Tuition Cost:	\$ 650.00	<u>Total Course Fee</u>
Administrative Fees & Materials:	\$ 245.00	\$ 995.00
Registration Fee (non-refundable):	\$ 100.00	

Minimum deposit of \$ 325.00 is due at registration in order to reserve your place in the class. This includes the \$100.00 non-refundable registration fee.

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

- Paid in Full \$ 995.00 at the time of registration
- Payment Plan*
 - \$ 325.00 at registration
 - \$ 235.00 at the end of the 2nd week
 - \$ 235.00 at the end of the 4th week
 - \$ 200.00 at the end of the 6th week

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

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, will result in a refund of all funds 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 or 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/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 course slot with no penalty. They may repeat the already completed sessions, if desired, at no additional charge or may pick up where they left off in the course previously. Physician's documentation is required in 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.

Course Requirements/Materials

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

- ❖ **PPD / TB SKIN TEST RESULTS** – must have negative documentation within the past 12 months
- ❖ **HEALTH EVALUATION** – form available through MMTC’s office or on the official website
- ❖ **HEPATITIS B VACCINE** – have completed or started the series of Hepatitis B vaccines and/or signed the Hepatitis B Vaccine Advisory
- ❖ **OFFICIAL HIGH SCHOOL TRANSCRIPTS or OFFICIAL COPY OF A GED SCORE** (Copies of diplomas, equivalency certificates, and unofficial copies cannot be accepted. An official copy must be mailed to our facility or delivered in person. Faxed copies do not constitute as “official”.)
- ❖ **PHLEBOTOMY STUDENT LIABILITY INSURANCE** – can be purchased through any provider. Our office does have recommendations if your insurance company does not offer this.

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: _____

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!



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



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. 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 MMTC 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



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



WAIVER OF LIABILITY AND ASSUMPTION OF RISK AND CONSENT

General Information – During this course you will be participating in activities in which learning by students requires the use of human subjects as part of the training. As a part of these learning activities you will be asked to perform specific skills, as well as be the subject of the specific skills practiced by other students. These learning activities will be conducted under the supervision of the course instructor.

Benefits – The activities listed have been selected because they are skills essential to the learning process and realistic practice is essential for optimum learning.

Bloodborne Pathogen Exposure – It is important that you be aware that blood and other body fluids have been implicated in the transmission of certain pathogens, particularly the Hepatitis B virus (HBV) and Human Immunodeficiency Virus (HIV), the virus for Acquired Immune Deficiency Syndrome (AIDS). In order to minimize risk of exposure to bloodborne pathogens, the student must agree to follow all Standard Precautions guidelines, as well as comply with regulations outlined in the OSHA Pathogen Standard.

Risks/Discomforts – Participation may create some anxiety or embarrassment for you. Some procedures may create minor physical or psychological discomfort.

Your Rights – You have the right to withhold consent and to withdraw consent after it has been given. You may ask questions and expect explanation of any point that is unclear.

LEARNING ACTIVITY	SPECIFIC BENEFIT	RISK/DISCOMFORT
<i>Venipuncture using both evacuated tube system and syringe system</i>	<i>Student gains experience needed prior to performing procedures on actual patients</i>	<i>Possibility of hematoma or bruising; slight temporary discomfort with procedure; slight risk of temporary nerve inflammation</i>
<i>Skin puncture of the finger tip</i>	<i>Student gains experience needed prior to performing procedures on actual patients</i>	<i>Slight, temporary pain upon puncture; minimal possibility of infection (provided area is kept clean)</i>

I have read the above information and I acknowledge my understanding of the risks and benefits described. My questions have been answered and I agree to participate as a subject in the learning activities listed above. I further understand and hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE, Matrix Medical Training Center, their officers, agents, instructors, or employees (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or any of the property belonging to me, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in the above listed learning activities, or while in, on or upon the premises where such learning is occurring.

Student Signature

Date

Parent/Guardian Signature (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 MMTTC 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)