

Student ID _____ Date Application Received _____ (For Office Use Only)

Choffin Career and Technical Center Adult Education (CCTC AE) Phone 330.744.8723 or 330.744.8720

HEALTH PROFESSIONS ADMISSIONS APPLICATION**Along with this application you must submit the \$30.00 Nonrefundable Registration Fee.**Submit payment in the form of cash or money order (no personal checks) payable to: Youngstown City Schools.**Application can be submitted to Choffin CTC Adult Education ~ 200 E. Wood St. ~ Youngstown, Ohio 44503****Program of Interest:** **Dental Assisting** **Practical Nursing** **Surgical Technology**

Testing Fee(Nonrefundable):

(CASAS: n/a)

(TEAS: \$75.00)

(CASAS: n/a; Manual Dexterity: \$45.00)

PERSONAL INFORMATION: (Please print clearly.)

First Name:

Middle
Initial:

Last Name:

Street Address:

County:

City:

State:

Zip:

Primary Phone:

Secondary Phone:

Previous Last Name (if applicable):

EMAIL ADDRESS:Date of Birth
(MM/DD/YYYY):

Age:

Social Security Number:
- -Gender: Female Male**EDUCATIONAL HISTORY:**

Highest Level of Education (check only one):

 High School High School Equivalent Associate's Degree Bachelor's Degree Post-Baccalaureate

Degree Major: _____

Name of High School/Testing Location: _____

City/State of High School/Testing Location: _____ Grad/HS Equivalent (MM/YY): ____/____

Colleges or Post-Secondary Programs you have previously attended:

Name of School/College: _____ From (Month/Yr): _____ to _____

Name of School/College: _____ From (Month/Yr): _____ to _____

Do you have a current STNA Credential? Yes, Renewal Date: _____ No**FUNDING INFORMATION:** Pell Grant MCTA Case Manager _____ VA Interest-Free Payment Plan TRA/TAA Case Manager _____ Other _____ Student Loan BVR Case Manager _____Are you in default on any student loans? Yes NoAre you a Veteran? Yes, which Branch? _____ No**EMPLOYMENT DATA:**Currently Employed: Yes No

Current or Last Employer:

Employed From (Month/Year):

to

Current or Last Position:	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time
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EMERGENCY CONTACT:

Name:	Relationship:	Phone:
Address:	City:	State: Zip:

ADDITIONAL INFORMATION:

How did you hear about the Choffin Adult Education Programs?

<input type="checkbox"/> Referred by Individual or Past Student	<input type="checkbox"/> Advertisement	<input type="checkbox"/> Radio	<input type="checkbox"/> Facebook
<input type="checkbox"/> TV	<input type="checkbox"/> Billboard	<input type="checkbox"/> Mail (postcard)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Choffin Website	<input type="checkbox"/> GED	<input type="checkbox"/> Employer	

REPORTING INFORMATION: *(The following information is required for State, Federal and accreditation reporting. This information will only be used for statistical reporting requirements.)*

Ethnicity	Please Check All That Apply
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Limited English Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> Economically Disadvantaged
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Disabled
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Displaced Home Maker
<input type="checkbox"/> Multi	<input type="checkbox"/> Single Parent
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	
<input type="checkbox"/> White	

Authorization for Release of Information and Applicant Certification:

I hereby authorize the release of information to Choffin Adult Health Professions including information both oral and/or written regarding my records, character, conduct and performance.

I understand that all pre-entrance requirements must be met and a criminal background check and satisfactory drug screen are required for participation in each program and clinical externship.

I further certify the information given on this application is true.

_____ / _____ / _____
Applicant's Signature **Date**

FOR OFFICE USE ONLY:

Fees Paid: <input type="checkbox"/> Registration	TEAS Testing	Dexterity	<input type="checkbox"/> Catalog Emailed
Date Paid:	Date Paid:	Date Paid:	
Test Date:	<input type="checkbox"/> Passed	<input type="checkbox"/> Failed	<i>Deficient Area(s):</i>
Reading _____			
Math _____			
2nd Attempt: P/F	3rd Attempt: P/F	Provisional: Y/N	
Interview Date:	Interview Time:	Interview & Testing Points Total:	
BCI Received Date:	FBI Received Date:		
Enrollment Status:	<input type="checkbox"/> Accepted	<input type="checkbox"/> Not Accepted	<input type="checkbox"/> Provisional Entry <input type="checkbox"/> Alternate List
High school transcript/GED or equivalent received:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drug Test Results:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive, area(s):	

Withdrew Application (date):	Reason:
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