Healing Spirit Healthcare, LLC

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CRMA & PSS Registration Form

Please write neatly, applications that are not legible will not be accepted.

NAME OF COURSE: _____ APPLICATION DATE: ___/___/_____

APPLICANT NAME: _____ DOB: _____
Last First Middle

SOCIAL SECURITY NUMBER (Last 4 Digits Only) _____
This information will only be viewed by Ila Mae (course instructor), her administrative staff, and the State of Maine Licensing & Regulatory Services for certification history and submission.

MAILING ADDRESS

STREET/PO BOX#: _____

CITY OR TOWN: _____

STATE: _____ ZIP CODE: _____ EMAIL: _____

HOME PHONE: _____ WORK / CELL PHONE: _____

CITIZENSHIP U.S.___ YES___NO___ IF "NO" WHAT COUNTRY: _____

MAINE RESIDENT: ___YES ___ NO IF "NO" WHAT STATE: _____

WILL YOUR TUITION BE SPONSORED BY AN AGENCY OR PROVIDER? ___YES ___NO
If someone other than yourself will be paying for you, please select "yes".

IF "YES" WHAT IS THE NAME OF THE AGENCY OR PROVIDER: _____

CONTACT PERSON: _____ TITLE: _____ PHONE: _____

Please note: It is the applicant's responsibility to make sure that the agency or provider who will be providing payment contacts the instructor to set up the terms of payment. Placement in the class is only guaranteed after payment has been made. All payments are due before the first day of class.

I hereby apply for enrollment in the above name course. If I am accepted, I agree to comply with the rules and regulations. I understand that the information on this form is CONFIDENTIAL and will only be used to determine my eligibility for the program I have selected. I also understand that any misrepresentation of information on this application and in any subsequent interviews with the Instructor may constitute adequate reason for disqualification of my application and enrollment as a student in the above named course.

_____ _____
Signature of Applicant Date