



Registration Form

Health Training Center | 340 Wood Road, Ste 102, Braintree, MA 02184 | Phone: 781-348-1808
Fax: 781-348-1809 | Email: registration@healthtrainingcenter.com

Course Information

COURSE	CAMPUS	MODULE	CLASS DATES	CLASS TIME

Student Information

Name: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Referred by: _____ Attended: Open House Interview

Age: _____ Ethnicity: Caucasian African-American Hispanic Asian Other

Currently Employed?: Full-Time Part-Time No High School Graduation/GED Date: _____

Payment Information

Payment Amount: \$ _____

Payment Type: Check/Money Order # _____ Visa MC Discover Last 4 Digits of Card: _____

Refunds: If you (1) withdraw in writing within 5 days of registering and before classes start; (2) if course is cancelled or (3) there are no vacancies, you will receive a full refund. If you withdraw in writing more than five days of registering and before classes start, you will be charged an Administration Fee of \$50. Once classes start, written withdrawals in the first quarter will be charged 25% of the course, plus cost of the books and Administration Fee. N See M.G.L. Chpt 355 13k or call us.

I certify that all information I have given is complete and accurate to the best of my knowledge; and, if admitted, I agree to observe the rules and regulations of this campus/program. I understand failure to do so could result in my dismissal.

Signature: _____ Date: _____