



Medical Billing & Coding Class SPRING 2020

APPLICATION

Date: _____ (Please use legal name that is identified on your driver license or social security card)

Name: _____
(Last) (First) (Middle/Maiden)

Mailing Address: _____ Telephone No. (____)____ - _____

(City) (State) (Zip Code) (County)

Email address: _____ Date of Birth: ____ - ____ - ____

Race: _____ Sex: Male _____ Female _____ U.S. Citizen: No _____ Yes _____ Legal Alien No _____ Yes _____

Place of Employment: _____

Public Agency _____ Private Agency _____ Title of Position _____

Business Address: _____ Telephone No. (____)____ - _____

(City) (State) (Zip Code) (County)

Have you ever been convicted of a misdemeanor or felony? _____ Yes _____ No

IF yes, please indicate nature of conviction and date: _____

How did you hear about MedEd Services training classes?

____ Website ____ Family/Friend ____ Referral (by who?) _____
____ Job fair ____ Social Media ____ Newsletter



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REQUIRED PREREQUISITIES (Please attach all documents that are checked)

High School Diploma/GED

Proof of AP/Medical Terminology Background, OR

2 years of healthcare experience w/signed documentation from Physician/Employer on letterhead

NOTE: CRC test is required for those not meeting the above prerequisites.

I. FACTORS AFFECTING COMPLETION OF ASSIGNMENT

1. Do you plan to be employed during the skills/training class? Yes No
 - 1) If yes please answer the following:
 1. Number of hours per week: _____ Time: _____ to _____
 2. What days? _____
2. Because all of your assignments will be online, do you foresee any problems with computer and/or internet issues? Yes
 1. If yes, please explain _____
3. Please note any handicaps or special needs you have that may impact the type of placement training you receive: _____

II. EDUCATION

High School Diploma

Technical/Trade Certification (Specify type of certification and list the institution certificate received from)

- 1) _____
- 2) _____
- 3) _____



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UNDERGRADUATE EDUCATION (Specify type of degree, discipline and year)

- 1) _____
- 2) _____

*Have you previously attended MedEd Services? _____ Yes _____ No

III. WORK EXPERIENCE

Agency/Location/Telephone	Dates	Description of Job Duties

IV. CAREER INTERESTS

1. What are your current education and career goals?

2. What personal strengths, qualities and/or abilities do you possess that would be an asset to you in this skills/training class?



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3. What knowledge, information, or experience do you hope to gain from this skills/training class?

V. I give my permission for the information contained in this application to be shared with other entities who are involved with my skills/training class. I have completed this application as accurately as possible, and I understand it and subsequent interview (s) will be utilized to determine the best employment/employer opportunity for me. I also understand that any false information deliberately included on this application will disqualify it and may disqualify me this class.

Student's Signature

Date

DO NOT WRITE BELOW THIS LINE (OFFICIAL USE ONLY) _____

Application:

Received on _____ Reviewed on _____
Date Date

Transcript/transfer credits evaluated on _____ GPA _____ Number of Hours _____
Date

Review Decision:

Approved _____ Approved conditionally _____ (List condition (s) below)

Disapproved _____ (List condition (s) below)



**Medical Billing & Coding Class
SPRING 2020**

Class Instructor _____ Telephone Number _____