NORFOLK ALLIED
HEALTH TRAINING CENTER

Non-refundable $25.00 must accompany this application

Student Information

Please Print

SS # _____

Last Name _____ First Name _____ M.I_____

Date of Birth _____ Age _____ Gender ____ Race _____

Address _____ City _____Zip code_____

Phone Number _____ Email _____

Emergency Contact

Name _____ Phone Number _____

Program Information

Check One:

- ☐ CNA
- ☐ PCT
- ☐ MA
- ☐ EKG
- ☐ HHA
- ☐ Pharmacy Tech
- ☐ Phlebotomy Tech
- ☐ Home Health Care
- ☐ High School Diploma

Date to enter program

_____

I agree to the following tuition $ _____. If I decide not to attend class I must withdraw according to Norfolk Allied Health Training Center policies. If I fail to properly withdraw a refund will be issued according to Norfolk Allied Health Training Center policies. I have red, and agree to all policies included in the school catalog.

Student Signature _____ Date _____

Staff Signature _____ Date _____