**A close up of a logo

Description automatically generated**

**S&H Training Center, Inc.**

**Student Registration Form**

Complete the form below and mail, email or fax with payment or payment authorization to:

S&H Training Center, Inc.

921 Lakeridge Way SW #100

Olympia, WA 98502

Email: sarah@sandhtraining.com

Fax: 360-339-4476

**STUDENT INFORMATION**

**Last name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI**: \_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_ **Zip**: \_\_\_\_\_\_\_

**County**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY

**Have you earned a High School Diploma or GED?**  Yes  No

If yes, what school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What year? \_\_\_\_\_\_\_  
 If no, you are required to take an English competency test before enrolling in the CNA or HCA classes.

**Class(es) you wish to register for** (check all that apply):

Certified Nursing Assistant $800 \*  
 (includes BLS, First Aid and HIV/AIDS)

Home Care Aide $550 \*  
 (includes Orientation & Safety,   
 Core Basic, Dementia, Mental Health,  
 and skills)

Dementia Level 1 $80

Mental Health Level 1 $80

Nurse Delegation Core $50

Nurse Delegation Diabetes $50

Continuing Education Units (12) $80

Orientation & Safety Training $50

HIV/AIDS Training $80

BLS Healthcare Provider $65

Heartsaver First Aid $65

HCA Skills Refresher $250

\*Requires a $200 deposit at time of registration, the rest is due the first day of class

**Payment Information**

**Option 1: Check**

Check #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Enclosed: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Option 2: Credit Card**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **S&H Training Center, Inc. Credit Card Authorization Form** | | | | | | |
| **Name as it appears on card:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Type of card:**  Amex  Discover  Master Card  VISA  MM/YYYY | | | | | | |
| **Credit Card #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Expiration Date:** \_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Billing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **State:** \_\_\_\_\_\_\_\_\_ | | **Zip Code:** \_\_\_\_\_\_\_\_\_ | | |
| **Phone:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **AUTHORIZED USER OF CREDIT CARD** | | | | | | |
| **Name:** S&H Training Center, Inc. | | | | | | |
| **Phone Number:** 360-539-7423 | | | | | | |
| **Relation to Card Owner**: Service Provider | | | | | | |
| **Type of Charges:** Training services tuition and deposits | | | | | | |
| **Authorized Amount:** $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **AUTHORIZATION OF CARD USE** | | | | | | |
| I certify that I am the authorized holder and signer of the credit card referenced above.  I certify that all information above is complete and accurate.  I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above in the “AUTHORIZED AMOUNT” field. If additional charges are going to be authorized a new form will have to be completed. | | | | | | |
|  | | | | | | |
| SIGNATURE |  | | | | DATE |  |

**Option 3: Third Party** (e.g. VA, Voc. Rehab., L & I, Work Source, Employer)

List third party payer company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Contact person name**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact person phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Option 4: Cash**

Please do NOT mail cash. Stop by the office if you wish to pay with cash, and please have exact amount.

**STUDENT DATA COLLECTION FORM**

The Workforce Board (the state agency that regulates this school) requires that we ask you for this information, by law (RCW 28C.10.050). Providing your social security number is voluntary. By law, the information you provide on this form cannot be given out by any state agency as public information. The Workforce Board will not disclose data to anyone except authorized Workforce Board employees or contractors working on specific research activities, who follow strict confidentiality procedures. This format follows the information required to be submitted by the school as part of the annual student data report.

**S&H Training Center, Inc**

**921 Lakeridge Way SW #203  
Olympia, WA 98502**

**360-539-7423**

**www.SandHtraining.com**

Last Name: First Name: MI:

Address: City: State: Zip:

Phone Number: Date of Birth: / /

Social Security Number: - -

Race (Check only one box):

White/Caucasian  Asian

Black/African American  Multiracial

American Indian or Alaska Native  Other

Hawaiian Native or other Pacific Islander

\*Are you Hispanic in origin?  Yes  No Sex:  Male  Female

\*Are you disabled?  Yes  No

\*Are you a military veteran?  Yes  No

Highest grade completed:

Less than high school graduation  Certificate (less than 2 years)

High school graduate  Associate degree

GED  Bachelor’s degree

Some post high school, no degree/certificate  Master’s degree or higher

Student Signature Date

School Representative Signature Date