EDUCATION & CAREER RESOURCES OF GA

Please print clearly, complete all sections, sign and date application
All information obtained in this application will be held in strict confidence, subject to applicable laws

Di does not discriminate regardless of Race, National origin, Age, Sexual Orientation or Physical disabilities.

Name: _____
Last First Middle

Telephone ( ) Cell Phone: ( ) E-mail :

Address: **Apt#**

City: **Zip code:**

S.S.N. _____/___/_____ **Gender: Male☐ Female ☐**

Marital Status: Married☐ Single ☐ Divorced ☐

Date of Birth: ___/___/_____ **Place of Birth:**

Place of Employment:
Company Name: Phone #:

Emergency Contact
(Name): _____
Last First Middle
Relationship: Telephone #:

Educational Background:
Highest level of education completed: _____

G.E.D/Equivalent: _____

Professional Background:

Please state any previous Medical skills/experiences:

Please Select Program and Schedule:

1.	C.N.A	Monday-Thursday	AM{ }	PM { }
2.	EKG/Phlebotomy	Thursday/Friday	AM{ }	PM { }
3.	P.C.T/EKG/Phlebotomy	Thursday/Friday	AM{ }	PM { }
4.	Clinical Medical Asst.	Monday-Wednesday	AM{ }	PM { }
5.	PCT only	Thursday/Friday	AM{ }	
6.	Medication Aide	Tues/Wed/Thurs	AM{ }	
7.	CPR/First Aid	Wednesday/Friday	AM{ }	PM { }

4055 Lawrenceville Hwy, Lilburn GA 30047 Phone: (770) 717 – 0310 Fax: (770) 717 - 0311

Program Sponsor:

1. Government (WIA) ☐
2. Organization/Corporation ☐
3. Individual ☐
4. Other: _____

Please state the reason why you are interested in this program(s):

_____
_____
_____

Please note that the application fee is $50.00 which is non-refundable and non-transferable.

**** Please be advised that all applicants will be required to complete an assessment exam, this exam will allow ECR to determine the applicant's ability to benefit from the program of choice. The examination consists of General Knowledge/Reading Comprehension questions which will evaluate aptitude and educational level prior to enrollment. Please be further advised that a Criminal Background check may be required prior to Clinical Rotation for some programs.****

I DECLARE THAT ALL STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE AND THAT ANY MISREPRESENTATION OR OMISSION IS CAUSE FOR DISMISSAL.

_____ _____
Applicant's Signature **Date Signed**

Office Use Only
(Please do not write in this area)

Interview Date: _____

Start Date: _____

Comments:

_____
_____
_____

_____
Admission Rep.

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