EDUCATION & CAREER RESOURCES OF GEORGIA

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

ECR of GA does not discriminate based on race, national origin, age, sexual orientation, or physical ability.

Name: _____
First Middle Last

Telephone: **Cell Phone:** **E-mail :**

Address: **Apt #**

City: **Zipcode:**

S.S.N. / / _ **Gender:** Select one

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

Place of Employment
Company Name: Phone # :

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

Educational Background
Highest level of education completed: _____

G.E.D/Equivalent: _____

Professional Background: _____

Please state any previous Medical skills/experiences: _____

Please Select the Program and Schedule:

1.	C.N.A	Monday-Thursday	AM ☐	PM ☐
2.	C.N.A Online	Monday- Thursday	AM ☐	PM ☐
3.	EKG/Phlebotomy	Thursday/Friday	AM ☐	PM ☐
4.	P.C.T/EKG/Phlebotomy	Thursday/Friday	AM ☐	PM ☐
5.	Clinical Medical Asst.	Monday-Wednesday	AM ☐	PM ☐
6.	PCT only	Thursday/Friday	AM ☐	☐
7.	Medication Aide	Tues/Wed/Thurs	AM ☐	
8.	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):

_____
_____
_____

How did you hear about our training program? _ Select one _____

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 the ECR of GA to determine the applicant's ability to benefit from their chosen program. The examination consists of General Knowledge and Reading Comprehension questions designed to evaluate aptitude and educational level before enrollment. Also, please be advised that a Criminal Background Check may be required before the 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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