COMPLETE PHLEBOTOMY TRAINING, INC.

Office phone: 951.672.2446 Office Fax: 951.672.2447

Web Site: phlebotomytraining.com

Email: ceusatcpt@live.com

ENROLLMENT AGREEMENT

Instruction will be provided at: 28125 Bradley Road, Suite #290 Menifee (Sun City), CA 92586

Student Name____ Date of Birth___________________

Address_________________________________ City________________ State________ Zip____________

Phone #________________________ Email____________________________________

This agreement is for the following EducationalProgram

CPT 1 (Certified Phlebotomy Technician 1) (Title)

No less than 84 (number of Clock Hours and Requirements for completion)

Registration Fee (non-refundable)	**$ 250.00**
STRF fee (non-refundable)	
Tuition	**$ 1,775.00**
Textbook	**$ 75.00**
Clinical Training Supplies	**$ 50.00**
Additional expenses and Fees paid to other Institutions	
National Exam Package	**$ 145.00 (online app. $120+ $25 sitting fee)**
CPR (American Heart Provider 5 CCR§71800 (f))	**$ 60.00**
Health Requirements (Cost dependent on individual's health provider 5 CCR §71800 (f))	**$ N/A**
Malpractice Insurance	**$ 15.00**

Program start date_________________________________ (mm/dd/yyyy) (first day of Basic)

Program completion date__________________________ (mm/dd/yyyy) (last day of in-class Clinical)

***Student Tuition Recovery Fund**

You must pay the state-imposed assessment for the Student Tuition Recovery Fund (STRF) if any of the following applies to you:

1. You are a student in an educational program, who is a California resident, or are enrolled in a residency program, and prepay all or part of your tuition either by cash, guaranteed student loans, or personal loans, and
2. Your total charges are not paid by any third-party payer such as an employer, government program or other payer unless you have a separate agreement to repay the third party.

You are not eligible for protection from the STRF and you are not required to pay the STRF assessment, if either of the following applies:

1. You are not a California resident, or are not enrolled in a residency program, or
2. Your total charges are paid by a third party, such as an employer, government program or other payer, and you have no separate agreement to repay the third party."(5 CCR §76215 (a)

5 CCR §76215(b) In addition to the statement described under subdivision (a) of this section, a qualifying institution shall include the following statement on its current schedule of student charges:
"The State of California created the Student Tuition Recovery Fund (STRF) to relieve or mitigate economic losses suffered by students in educational programs who are California residents, or are enrolled in a residency program attending certain schools regulated by the Bureau for Private Postsecondary Education.

You may be eligible for STRF if you are a California resident or are enrolled in a residency program, prepaid tuition, paid STRF assessment, and suffered an economic loss as a result of any of the following:
1. The school closed before the course of instruction was completed.
2. The school's failure to pay refunds or charges on behalf of a student to a third party for license fees or any other purpose, or to provide equipment or materials for which a charge was collected within 180 days before the closure of the school.
3. The school's failure to pay or reimburse loan proceeds under a federally guaranteed student loan program as required by law or to pay or reimburse proceeds received by the school prior to closure in excess of tuition and other costs.
4. There was a material failure to comply with the Act or the Division within 30-days before the school closed or, if the material failure began earlier than 30-days prior to closure, the period determined by the Bureau.
5. An inability after diligent efforts to prosecute, prove, and collect on a judgment against the institution for a violation of the Act."

However, no claim can be paid to any student without a social security number or a taxpayer identification number.

Student's Right to Cancel

You have the right to cancel your agreement for a program of instruction, without any penalty or obligations, through attendance at the first class session or the seventh calendar day after enrollment, whichever is later.
The student must exercise his or her right to cancel or withdraw by this date__________ (mm/dd/yyyy).
This Enrollment period is valid from____________ (mm/dd/yyyy) to_______________ (mm/dd/yyyy)

Refund Policy

After the end of the cancellation period, you also have the right to stop school at any time; and you have the right to receive a pro rata refund if you have completed 60 percent or less of the scheduled days in the current payment period in your program through the last day of attendance. If you have received federal student financial aid funds, you are entitled to a refund of monies not paid from federal student financial aid funds. A request to cancel or withdraw from the school must be in writing and either hand delivered or mailed to the following address: **28125 Bradley Road,STE 290, Sun City, CA 92586.** The effective date of cancellation or withdrawal will be the date notice is received by Complete Phlebotomy Training, Inc.

Loans

If you obtain a loan to pay for this educational program, you are responsible for repaying the full amount of the loan plus any interest, less the amount of any refund. Ed Code §94911 (f)
Federal or State Financial Loans
If a student is eligible for a loan guaranteed by the federal or state government and the student defaults on the loan, both of the following may occur:
(1) The federal or state government or loan guarantee agency may take action against the student, including garnishing an income tax refund; and.
(2) The student may not be eligible for any other government financial assistance until the loan at another institution until the loan is repaid. Ed. Code§94911 (g) (1) (2)
If a student has received federal student financial aid funds, the student is entitled to a refund of moneys not paid from federal student financial aid program funds.

Notice Concerning Transferability Of Credits And Credentials Earned At Our Institution

The transferability of credits you earn at Complete Phlebotomy Training, Inc. is at the complete discretion of an institution to which you may seek to transfer. Acceptance of the certificate you earn in Complete Phlebotomy Training, Inc. is also at the complete discretion of the institution to which you may seek to transfer. If the certificate that you earn at this institution is not accepted at the institution to which you seek to transfer, you may be required to repeat some or all of your coursework at that institution. For this reason you should make certain that your attendance at this institution will meet your educational goals. This may include contacting an institution to which you may seek to transfer after attending Complete Phlebotomy Training, Inc. to determine if your certificate will transfer.
(Ed. Code§ 94911 (h)) and (Ed. Code§ 94909 (a) (15))

Student Acknowledgments:

(1) "Prior to signing this agreement, you must be given a catalog or brochure and a School Performance Fact Sheet, which you are encouraged to review prior to signing this agreement. These documents contain important and performance data for this institution. This institution is required to have you sign and date the information included in School Performance Fact Sheet relating to completion rates, placement rates, license examination passage rates, salaries or wages, and the most recent three-year cohort default rate, if applicable, prior signing this agreement."

(Ed. Code§ 94911 (i) (1) Student initials___________

(2) I certify that I have received the catalog, School Performance Fact Sheet, and information regarding completion rates, placement rates, examination passage rates, salary or wage, and the most recent three-year cohort default rate, if applicable, included in the School Performance Fact sheet, and have signed, initialed, and dated the information provided in the School Performance Fact Sheet.
(Ed. Code § 94911 (i) (2) Student initials___________

I understand that this is a legally binding contract when signed by the student and accepted by this institution.

Student initials___________

Any questions a student may have regarding this enrollment agreement that have not been satisfactorily answered by the institution, may be filed with the
Bureau for Private Postsecondary Education at 2535 Capitol Oaks Drive, Suite 400 Sacramento, Ca. 95833.P.O. Box 980818 West Sacramento, Ca. 95798-0818.
Phone # (916) 431-6959, Toll free: (888) 370-7589 Fax- 916-263-1897
Website www.bppr.ca.gov.

A student or any member of the public may file a complaint about this institution with the Bureau for Private Postsecondary Education by calling 888-370-7589 toll-free or by completing a complaint form which can be obtained on the Bureau's internet website www.bppe.ca.gov

TOTAL CHARGES FOR CURRENT PERIOD OF ATTENDANCE	$ 2,370.00
ESTIMATED TOTAL CHARGES FOR THE ENTIRE EDUCATIONAL PROGRAM	$ 2,370.00
TOTAL CHARGES STUDENT OBLIGATED TO PAY UPON ENROLLMENT	$ 625.00
NON-REFUNDABLE CHARGES REGISTRATION FEE STRF FEE	$250.00

I understand that this is a legally binding contract. My signature below certifies that I have read, understood, and agreed to my rights and responsibilities, and that the institution's cancellation and refund policies have been clearly explained to me.

I,____,
(print name)

Understand that I am agreeing to pay the total cost of the program, as specified above, prior to receiving my Certificate of Completion.

Student's Signature____

Date____________________

Official's Signature____

Date____________________

COMPLETE PHLEBOTOMY TRAINING – REGISTRATION FORM (PLEASE PRINT)

I am currently licensed yes___no___

If yes, License # ____________________

___EMT ___LVN ___ RN ___ PA ___ NP ___ MD ___ CLS ___Other ____________

Student Name ____
Address ____City ____________________________
State _______Zip ______________Phone ( ) _______ - _____________ Cell ( ) ______ - ____________
E-Mail ____
Date Of Birth ___________________ Age ________ Gender _________
Social Security # ______________ - __________ - ______________
High School _______________________________________City ______________________State _________
Graduation: Month __________Year___________ ***Copy Of H. S. Diploma Or GED Will Be Required***
Or GED Completion Date _____________ ***At Time Of Registration***
Session Requested __________________________ Registration Confirmation Via E-Mail yes___no ___

EDUCATIONAL HISTORY

Field of Study ____
School Attended ____
City ____________________________ State _____________ Phone ( ) ________ - _____________
Dates Attended: From ____________________ To ______________________

WORK HISTORY

Institution ____
Address ____ City ______________________ State ___________
Dates of Employment ____
Position(s) Held ____
Specific Duties ____

ENROLLMENT CHECKLIST / PAYMENT METHOD

Date _________ Amount paid _________ Cash ____ Check # _________ CC ______
Scrub Top ____ Name Badge ____ Eng. Comp. Test ____ BkGd Check ____ Textbook ____ HW____
Diploma ____ Transcript ____ GED ____ Student Initial _______ Staff Initial ______

IF PAYING BY CHECK PLEASE WRITE DRIVERS LICENSE NUMBER, OF CHECKING ACCOUNT HOLDER, ON CHECK. CHECKS WILL BE ELECTRONICALLY DEBITED WHEN RECEIVED. IF PAYING BY CREDIT CARD**, PLEASE LIST CARD NUMBERS AND EXPIRATION DATE BELOW.

MC/VISA/DISC. _________-_________-________-________ EXP. DATE _____ / _____
SIGNATURE ____ ** AMT. TO BE CHARGED $ _____________
NAME ON CREDIT CARD ____

***** A CHARGE OF 3.5% + $3.00 WILL BE ADDED = (Fees And Charges Incurred, Are Passed On To Consumer)***

<u>PLEASE RETURN TO:</u>CPT • 28125 Bradley Rd. Ste. 290 • Menifee, CA 92586 0r FAX TO: 951-672-2447

Complete Phlebotomy Training, Inc.
Approved by the State of California
Department of Public Health
Laboratory Field Services Division
Registered with the B.P.P.E.

POTENTIAL EXPOSURE TO CONTAGIOUS INFECTIOUS DISEASES

A portion of the CPT Phlebotomy training is conducted in the laboratory/classroom setting. Students will perform blood withdrawal where contagious/infectious diseases may be present in any specimen, on any used equipment or spilled on any surface area during practice or demonstration. Latex/vinyl gloves will be supplied for protection; however, gloves are no guarantee against exposure. Your signature indicates that you are aware of the potential exposure to contagious infectious disease within phlebotomy laboratory training. Your signature acknowledges that you have knowledge and understanding of contagious/infectious diseases, such as, but not limited to AIDS, and HEPATITIS A, B, and C.

I UNDERSTAND, THAT I AM ENROLLED IN A PHLEBOTOMY CLASS IN WHICH PARTICIPATION IN THE PRACTICE AND DEMONSTRATION OF VENIPUNCTURE AND BLOOD WITHDRAWAL EXPOSES ME TO THE POTENTIAL OF CONTAGIOUS / INFECTIOUS DISEASES. I ACKNOWLEDGE THAT I HAVE THE KNOWLEDGE AND UNDERSTANDING OF THE CONTAGIOUS / INFECTIOUS DISEASES TO WHICH I MAY BE EXPOSED.

_______ Initial

PATIENT CONFIDENTIALITY STATEMENT

I VERIFY, BY MY SIGNATURE, THAT I FULLY UNDERSTAND THAT ANY AND ALL PATIENT INFORMATION I MAY COME INTO CONTACT WITH, WHILE ATTENDING THIS CLASS, OR WHILE IN ANY HOSPITAL OR ANY LABORATORY, SHALL REMAIN CONFIDENTIAL. I UNDERSTAND THAT MANY DIFFERENT PEOPLE USE THESE HOSPITALS AND / OR LABORATORIES TO MEET THEIR HEALTHCARE NEEDS, AND THAT I MAY SEE PEOPLE THAT I KNOW OR KNOW OF, WHILE AT ANY FACILITY. I FULLY UNDERSTAND THAT ALL PATIENTS HAVE THE RIGHT TO PRIVACY AND CONFIDENTIALITY WHILE RECEIVING MEDICAL TREATMENT. I UNDERSTAND THAT IT IS A PRIVILEGE TO BE ABLE TO USE THESE FACILITIES FOR CLASS TIME AND FOR THE BENEFIT OF HAVING ACCESSIBILITY TO A CLINICAL LAB. I AGREE TO KEEP ALL PATIENT INFORMATION CONFIDENTIAL AND PRIVATE.

_______ Initial

RELEASE OF LIABILITY

MY SIGNATURE ON THE LIABILITY, CONFIDENTIALITY, AND EXPOSURE FORM INDICATES THAT I FULLY UNDERSTAND THE FOLLOWING:

1. I MAY BE EXPOSED TO BLOOD BORNE PATHOGENS WHILE PERFORMING VENIPUNCTURE ON MY CLASSMATES.
2. I WILLINGLY AGREE TO ALLOW MY CLASSMATES TO PERFORM VENIPUNCTURE ON ME WHILE SUPERVISED BY MY INSTRUCTOR OR OTHER QUALIFIED CPT PERSONNEL.
3. I UNDERSTAND THAT IF I AM INJURED WHILE ON THE AMR, VHS OR ANY HOSPITAL OR LABORATORY PROPERTY THAT I AM FULLY RESPONSIBLE FOR SEEKING MEDICAL HELP AT A LOCAL MEDICAL FACILITY.
4. I AGREE NOT TO HOLD WANDA TARDY, CPT, AMR, VHS OR DESIGNATED HOSPITAL OR LABORATORY OR THEIR EMPLOYEES RESPONSIBLE FOR ANY INJURY I MAY SUSTAIN.
5. I AGREE TO FOLLOW ALL SAFETY PRECAUTIONS THAT HAVE BEEN SET FORTH BY THE INSTRUCTOR.
6. I AGREE TO USE THE SHARPS CONTAINER APPROPRIATELY.
7. I AGREE ***NOT*** TO RECAP NEEDLES.
8. I AGREE TO WEAR GLOVES.
9. I AGREE TO WASH MY HANDS BEFORE AND AFTER USING GLOVES.

I UNDERSTAND MY NAME AND SOCIAL SECURITY NUMBER WILL BE USED TO OBTAIN A BACKGROUND CHECK AS REQUIRED BY HOSPITAL / LABORATORY CONTRACT.

REPLACEMENT FEE SCHEDULE:

Copy of Cert.	$10.00
Original	$30.00
Book Replacement	$65.00

Complete Phlebotomy Training Inc.
Approved by the State of California
Department of Public Health
Laboratory Field Services Division
Registered with the B.P.P.E.

Confirmation of Liability, Confidentiality, Potential Exposure and Replacement Fee Statement.

I have read and acknowledge the Release of Liability, the Patient Confidentiality, Potential Exposure, and the Replacement Fee Schedule. My signature below confirms my acceptance of the previously mentioned policies and procedures stated in this Registration Packet.

I acknowledgeand understand that I must have all required documentation, including health check up and proof of CPR as well as malpractice insurance, submitted, no more than 30 days from the last day of clinical class. I also understand that I must complete the entire program, which includes Basic, Advanced and Clinical, including rotations (Externship) within 90 days from the first day of Basic class or I may be subject to repeating and paying for all of the above courses.

I understand that *CPT is a* State certified school and the class hours completed lead to certification as outlined by LFS guidelines. Matriculation of units to a junior college or other educational institution is dependant on said institution's policies and guidelines. There are no academic credits or units that transfer to other educational institutions per California higher education act of 1965 section 481. (This applies to the use of form 1098-T for tax purposes)

I understand my name and social security number will be used to obtain a background check as required by hospital/laboratory contract.

____
Student Signature

____
Student Name (Please Print Clearly)

____
Date (FIRST class session)