EEG PROGRAM APPLICATION

NAME: _____
First *Middle* Last

ADDRESS: _____
Street *Address*

_____
City *State* *Zip*

TELEPHONE: _____ D Cell D Home D Work

EMAIL: _____

Month I would like to begin classes: _____ **Year:** _____

The clinical portion of your education will come from the hands-on learning you will receive at our neurological facility. Please complete the section below to identify your ability to meet the eligibility requirements.

Highest Level of Education Achieved:	D High School/GED	D College
Will you be eighteen (18) years old or older at the time the first course begins?	D Yes	D No
Are you fluent in speaking and writing in English?	D Yes	D No
Are you able to walk and stand for long periods of time?	D Yes	D No
Are you able to lift forty pounds (40 lbs.)?	D Yes	D No
Are you certified or willing to become certified in CPR?	D Yes	D No
Do you currently work in a health care facility?	D Yes	D No
Are you currently performing the job of an EEG Tech?	D Yes	D No

I certify that the information contained in this application is true and complete to the best of my knowledge. I fully realize that omission or falsification will be sufficient reason for rejection of this application or dismissal from the program.

Applicant Signature: _____

Date: _____

Applications can be emailed to _____or faxed to 407-208-0709