WALTERS STATE
THE GREAT SMOKY MOUNTAINS COMMUNITY COLLEGE

HEALTH CARE NON-CREDIT CONTINUING EDUCATION - REGISTRATION FORM

STUDENT INFORMATION *(Information requested for person registering for the class)*

Social Security Number ________-________-________
(If U.S. Social Security number is not available, a student I.D. will be assigned)

Birthday ________/________/________
mo day year

*** For Reporting Purposes Only

Sex ❒ Male ❒ Female **Citizenship** ❒ U.S. Citizen ❒ Other ________

Race ❒ Asian/Pacific Islander ❒ Black/Non-Hispanic ❒ Alaskan Native ❒ Hispanic ❒ Native American Indian ❒ White

Student Name ____
Last First Middle

Home Address ____
Street or RFD City

____
County State Zip Code

Home E-Mail Address ______________________ **Work E-Mail Address** ______________________

Phone #'s: **Home** ______________ **Work** ______________ **Emergency** ______________ **Cell** ______________

Chapter 759 of the State of Tennessee Public Acts of 1984 provides that "no person who is required to register for the federal draft shall be eligible to enroll in any state post-secondary school until such a person has registered for the draft." Please check below:

❒ I certify that I am registered or will register with Selective Service. I will provide the number if requested.

❒ I am not registered for the Federal Selective Service because I am:

- ❒ Female. ❒ Not 18 years of age. I will register when required. ❒ I am on active Duty in the armed forces.
- ❒ Not required since I was born before 1960 or I am a foreign student on an F-1 Visa.
- ❒ Not yet required. I am a permanent resident of the Trust Territory of the Pacific Islands or the Northern Mariana Islands.

❒ I am a veteran of the United States Armed Forces.

☐ WIA
☐ TRA
☐ Voc. Rehab./DOLWD
☐ Other ________________
☐ ITA or similar received

____
Counselor Name

____
Counselor Contact Information/Office

HEALTH CARE NON-CREDIT COURSE INFORMATION *(check all that apply)*

❒ **Morristown Campus** ❒ **Greeneville Campus** ❒ **Sevierville Campus** ❒ **GCFT** ❒ **Claiborne County**

❒ **C.N.A.** ❒ **Phlebotomy** ❒ **Reg. Dental Asst** ❒ **EKG Tech** ❒ **Other** ______________________

Start Date ____________ End Date ____________ Days ____________ Time ________ CEU # ______________________

Class Fee: $ ____________ Clinicals Fee $____________ Total Fee $ ______________________

Total fee can be paid at any WSCC campus business office only. Class size is restricted. Enrollment is based on the availability of class.

* Textbooks, scrubs, State Board and background check fees are not included. Proof of TB test may be required for admission.
** Medical centers where clinicals are held require that students pass a criminal background check through Verified Credentials, Inc. You should complete the on-line questionnaire at least one week before class starts. If you cannot pass background check, you will be entitled to a refund provided class has not started. Once class begins, there are no refunds.
*** Attendance is required. Poor attendance or poor grades on tests will be grounds for removal from the class with no refund.
**** Clinical dates, times and location are based on the availability of the medical centers patient loads and staff. Clinicals will be offered as quickly as possible, but we cannot guarantee how soon a student can start clinicals after completing the course work. Clinical location providers reserve the right to only accept students who meet their professional standards.

I certify that all information provided on this form is accurate. I am aware that this course is a "non-credit" course, and that continuing education units may be awarded. I am aware there will be no refunds other than for cancellation of the class by the college. For extenuating circumstances this may be appealed through the Dean of Community and Economic Development. There is a $25.00 fee if you want to reschedule a class.

____
(Student Signature) Date

Internal Use Only

❒ **Entered in Data Base** ______________________ **FRS 1-15660-0180**

FOR BUSINESS OFFICE USE ONLY

Date ________ Fee $ ________ Paid by ____________ Paid for ____________ Receipt # ____________ By ____________

☐ Cash ☐ Check # ______ ☐ Debit Card (Check Card)** ☐ Credit Card: VISA** ☐ Credit Card: MasterCard** ☐ Credit Card: Discover**

IF mailing payment by credit card: Credit card billing address must match registration address

Credit Card # ______________________ 3 Digit Code ________ Expiration Date ______________