# NorthWest Arkansas Community College
## Division of Health Professions
## Registration Form

Student Name (Last) _____(First)_____(MI) _____

Social Security Number _____ - _____- _____ E-Mail _____

Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____

Gender: □ MALE □ FEMALE Date of Birth (Month/Day/Year): _____ / _____ / _____

Ethnic Origin: □ Asian □ Hispanic □ Black/African □ American Indian/Alaskan □ White/Caucasian □ Decline Response

Place an X in the first column to indicate which course you want to enroll.
All classes will be held in the Center for Health Professions room 2011.
Space is limited – you will be contacted via email once enrollment is complete.

| X | Course Title | Office Use Only | M | T | W | T | F | S | Date | Time | Cost |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | EMT Refresher Course | 020142-2115 | | X | | X | | | February 25, 2014 to March 13, 2014 | 6:00pm – 10:00pm | $120.00 |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

I understand that I must comply with the following three items below:

1. submit this application to the address/email below at least two days before the scheduled class
2. after registration form is submitted, I will receive an email confirmation and I must make payment to the NWACC cashier's office before the class*(If payment is made by third party billing – see instructions below)
3. if I don't pay for the course, my CPR card will be held until payment has been made

Signature _____ Date _____

***Third Party Billing** – If a third party (your employer or government agency) will be paying your tuition and fees, a letter of authorization to bill must be received with this registration form. Any part of the tuition not covered by the third party is your responsibility and must be paid by the scheduled payment deadline. If you have any questions regarding third party billing, please call me at 479-619-2261.

**The letter of authorization should contain the following information:**

1. **Student's name and social security number**
2. **Third party name and address (letterhead is sufficient)**
3. **Course title, date, and tuition amount**

---

Mail, E-mail or FAX registration form to:

NWACC Health Professions **OR** sslay@nwacc.edu **OR** 479-619-4254

Attn: Sherry Slay
One College Drive
Bentonville, AR 72712