Date: _____

I understand and agree that I must undergo a Nurse Aid registry check with the Department of Aging and Disability Services, prior to entrance into the Patient Care Technician program.   I am furnishing my information and understand that if my Nurse Aid registry checks return with questionable findings, it can result in not being able to enroll in the Patient Care Technology program.

_____
Signature

_____
Full Name (PRINT CLEARLY)

_____
Other names (maiden, married)

_____
Date of Birth

_____
Social Security #

_____
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