# AMERICAN COLLEGE OF HEALTHCARE

# DISCLOSURE

We are pleased that you are applying for admission to the AMERICAN COLLEGE OF HEALTHCARE. Please refer to individual program descriptions for specific information regarding the program admission requirements, prerequisites, application deadline dates, start dates, tuition/fees, and advising. We look forward to receiving your application and working with you throughout the admissions process.

The AMERICAN COLLEGE OF HEALTHCARE provides educational opportunities without regard to race, color, religion, sex, age, national origin, marital or veteran status, sexual orientation, physical or mental condition(s) so long as the condition(s) do not limit the applicant's ability to perform essential functions of a student with or without reasonable accommodations. An individual's qualifications must meet the established criteria for admission to the selected program of study.

**PLEASE READ CAREFULLY. EACH PARAGRAPH MUST BE READ AND INITIALED AND THE APPLICATION MUST BE SIGNED. For the purpose of this disclosure, ACH are otherwise known as AMERICAN COLLEGE OF HEALTHCARE.**

It is my understanding that I shall not be considered for admission until I have submitted all required information. I also agree to inform the school of any changes in the following: plans to attend the program; address; and/or legal name. ________ Initial

I consent to the release to ACH from current and former employers, schools, law enforcement agencies, and other individuals and organizations, information relevant to my consideration for enrollment. Such parties may rely upon this authorization as a waiver of any claim whatsoever I may have as a result of the party responding candidly to an inquiry from ACH. In providing this release, I acknowledge that because adverse references from any of the above will be evaluated in the admission process these may result in non-acceptance to ACH. ________ Initial

I understand that a false statement or omission of facts and circumstances on this application and/or on other documents related to my qualifications and background may be grounds for not enrolling or for dismissing me from the program after I begin classes. I certify that to the best of my knowledge and belief, all statements are correct, complete, current, and made in good faith and that I will attach information as necessary to meet this disclosure requirement. ________Initial

If enrolled, I understand that I will be subject to and agree to abide by ACH's policies, procedures, rules, and practices. I also understand that I may be required to agree and submit to alcohol and/or substance abuse tests prior to my acceptance by ACH and to periodic testing thereafter at the discretion of ACH, in accordance with applicable ACH policies and/or practices. ________Initial

I understand that I may be accepted into a program prior to completion of background and/or reference checks or investigations. If such inquiries, upon completion, establish information that in ACH's opinion makes me unqualified, I understand I will be dismissed promptly. ________Initial

I agree that ACH may, without further consent, make lawful use of any photographic picture or video image it may make or cause to be taken of me. ________Initial

I understand that an applicant who meets all requirements is not guaranteed admission into the program. _________Initial

SIGNATURE: ________________________________________________

PRINT NAME: ______________________________ DATE: ____________________

THANK YOU FOR YOUR INTEREST IN OUR SCHOOL!

# AMERICAN COLLEGE OF HEALTHCARE

# APPLICATION FOR ADMISSION

**Program name: _________________________ Program start date: __________________________**

***Please enter the name of the program you are interested in. Indicate desired start date and time.***

## PERSONAL INFORMATION

Legal Name ______________________ Mr. / Ms. ________________________________________
Last First Middle (Maiden)

Preferred Name (e.g., Cathy for Catherine) ____________________ Email Address _________________________

Social Security Number__________ -___________-___________ Date of Birth __________ / __________ / __________

Current Mailing Address:__________________________________________________________
Street Name and Number PO Box

__________________________________________________________
City State Zip Code

Telephone: Home (___) ________________Work (____) ______________Cell (____) ____________________

Emergency Contact:

Name (Last, First) ________________________________________________Relationship__________________

Address (Street/City/State/Zip Code) _______________________________________________________

Telephone (Day) ____________________________________ (Evening) _____________________________

Citizenship: ☐ U.S. Citizen ☐ Naturalized U.S. Citizen ☐ Permanent Resident Country of Citizenship _______________
☐ Other_______________ Alien Registration Number _______________________________

**Attach notarized copy of both sides of immigration card or naturalization document or present the original card to the Admissions Office for copying. American College of Healthcare does not sponsor student visas.**

Are you legally eligible for educational training in the United States? ☐ Yes ☐ No

Is English your first language? ☐ Yes ☐ No
If no, when did you take the TOEFL exam? Month/Year Taken* ________ What was the Score?* ________

***Official TOEFL test results required. Must have completed the TOEFL exam within the past 5 years scoring a minimum of 79 (internet-based), 215 (computer- based) or 550 (paper based).**

Have you ever been convicted of or are you presently under indictment for any felony or misdemeanor offense other than traffic violations?* ☐ Yes ☐ No If yes, please explain in an attached letter.

Failure to disclose the existence of a felony or misdemeanor offense will result in your immediate dismissal from the school.

***A California State Police Criminal History Record check will be performed on all admitted students.**

Attention Applicants: Regulatory Boards may refuse to admit a candidate to any examination, or may refuse to issue a license or certificate to any applicant based on a number of both criminal and/or unprofessional conduct reasons. Access the following Regulatory Boards for a list of applicable offenses: Surgical Technology – **www.lcc-st.org**

Are you currently on probation? ☐ Yes ☐ No If yes, please explain in an attached letter

- Health Care Providers Only: Have you ever been disciplined in any manner by a state regulatory agency for any reason? ☐ Yes ☐ No If yes, please explain in an attached letter
- Program Eligibility: Are you presently or have you previously been, as a provider, excluded, debarred, suspended, sanctioned or otherwise found ineligible to participate in the Medicare or Medicaid programs or Federal procurement and non-procurement programs? ☐ Yes ☐ No If yes, please explain in an attached letter

How did you hear about our school? (Example: name of web site, newspaper name, name of the event / fair, etc.)

## ACADEMIC INFORMATION

Have you ever applied to AMERICAN COLLEGE OF HEALTHCARE before? ☐ Yes ☐ No
If yes, please list Program Title(s) / Date(s):

Have you ever attended AMERICAN COLLEGE OF HEALTHCARE before? ☐ Yes ☐ No
If yes, please list Program Title(s) / Date(s):

Have you ever been dismissed or suspended from high school or college? ☐ Yes ☐ No
If yes, please explain (include date(s), name of institution(s) and reason(s) in an attached letter

Have you attended another school similar to the one to which you are applying? ☐ Yes ☐ No
If yes, Please list Institution and Program Title(s)/Date(s):

Are you interested in having your courses reviewed for possible advanced placement or transfer credit? ☐ Yes ☐ No
If yes, official transfer evaluation forms and fee apply. Please contact Admissions for further instructions.

**LIST ALL OF THE SCHOOLS YOU HAVE ATTENDED (attach continuation sheets if necessary)**

| School Name & City/State | Dates Attended | Did You Graduate? | Degree/License Diploma/Certificate |
|---|---|---|---|
| High School(s) | | | |
| | To | Y N | |
| | To | Y N | |
| College(s) | | | |
| | To | Y N | |
| | To | Y N | |
| | To | Y N | |
| | To | Y N | |
| | To | Y N | |
| Other (Specify) | | | |
| | To | Y N | |

Do you have a High School Diploma Y or N
If you hold a High School Equivalency Certificate (GED), please list:
State in which you received certificate: ________________________________ Date received: ____________
Certificate Number: ______________________________________________ Score: ______________

**Please provide a photocopy of any health profession licenses or certifications you have received.**

## REFERENCES

1. Name: ___________________________ Address: ______________________________________________________________
   Phone Number: ___________________________ Relationship: ______________________________________________

2. Name: ___________________________ Address: ______________________________________________________________
   Phone Number: ___________________________ Relationship: ______________________________________________

## EMPLOYMENT INFORMATION

Have you ever been employed by ACH? ☐ Yes ☐ No If yes, Department? ___________________________

Supervisor's Name/Title/Phone: ____________________________________________________________________________

Your Position Title: _________________________ Riverside Employment Dates: From _____________ To _____________

Have you ever been terminated from employment? ☐ Yes ☐ No If yes, please explain in an attached letter.
May we contact your past and present employers? ☐ Yes ☐ No If no, please explain in an attached letter.

**Work Experience: Start with most recent position, to include all: permanent, temporary, military, and volunteer work. Please explain any lapses in time. (Attach continuation sheets if necessary.)**

______________________________________________________________________________
Name of Company Position Held Dates Worked (Mo. /Yr.)

______________________________________________________________________________
Street/ City/ State/ Zip Phone Number

______________________________________________________________________________
Immediate Supervisor & Title Reason for Leaving

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______________________________________________________________________________
Name of Company Position Held Dates Worked (Mo. /Yr.)

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______________________________________________________________________________
Name of Company Position Held Dates Worked (Mo. /Yr.)

______________________________________________________________________________
Street/ City/ State/ Zip Phone Number

______________________________________________________________________________
Immediate Supervisor & Title Reason for Leaving

## FINANCIAL INFORMATION

AMERICAN COLLEGE OF HEALTHCARE requires timely payment of all fees and tuition in order to begin or continue your education. Our Tuition Planning Department can answer questions and provide information that may help you meet your financial obligations to the school.

Will you be applying for financial assistance? ☐ Yes ☐ No
Would you like our Tuition Planning Department to contact you? ☐ Yes ☐ No
Military Service History: ___ None ___ Veteran ___ Currently Active/Reserve
Are you eligible for Veterans' educational benefits? ☐ Yes ☐ No