



Associate Degree Student Application

1507 County Hospital Road
Nashville, TN 37218

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The Associate of Applied Science in Surgical Assisting degree is a distance learning program designed to provide surgical assisting graduates of Meridian Institute of Surgical Assisting the opportunity to attain their associate degree. By nature all communications, submissions, and transmissions will be provided electronically. In addition, E-mail is considered the official communication between student and school.

It is the ongoing policy of our company to afford equal educational opportunities to qualified individuals regardless of their race, color, religion, sex, national origin, age, physical or mental handicap, veteran status, or because they are disabled veterans, and to conform to applicable laws and regulations.

ELECTRONIC CONSENT

I consent to do business electronically with Meridian Institute of Surgical Assisting. I understand that in order to change this option and opt out of doing business with Meridian Institute of Surgical Assisting at anytime in the future I must contact The Program Director.

I choose to opt out of doing business electronically with Meridian Institute of Surgical Assisting. I understand that in order to change this option and opt in and consent to doing business with Meridian Institute of Surgical Assisting at anytime in the future I must contact The Program Director.

IDENTIFYING INFORMATION

Gender:

Male

Female

Race:

Caucasian

Hispanic

African American

Other

Email:

Last Name:

First Name:

Initial:

Birth Date:

Birth Place:

Social Security Number:

Home Address:

City:

State:

Zip:

Contact Phone Number:

EMPLOYMENT INFORMATION (Most current to previous)

Current Employer:

Current Employer Address

Current Job Title:

Current Supervisor:

From:

To:

EDUCATION:

I am a graduate of Meridian Institute of Surgical Assisting. Graduation Date:

I am not a graduate of Meridian Institute of Surgical Assisting.

Official transcripts for all college level work must be send to the Academic Dean. Official transcripts from Meridian do not need to be sent. They will be verified from your academic file.

Certification:

Certification Number

Expiration Date:

CSFA

CSA

CST

Have you ever been publicly or privately warned, reprimanded or censured by a licensing body, a public or private certifying agent, a medical staff, a hospital or other health care facility?

Yes (Explain below)

No

GAINFUL EMPLOYEMENT

See important Information about educational debt, earning, and completion rates of students who attended this program by visiting:

<https://web.meridian-institute.edu/gedt2>

I, _____ acknowledge that I have received the above GE Disclosure information.

Signature

Date

AUTHORIZATION AND RELEASE

I understand and agree that by applying to Meridian Institute of Surgical Assisting, Inc. it is my responsibility to provide accurate and sufficient information to enable them to evaluate my qualification and eligibility, including information regarding my education, licensure, training, experience, competence, professional ethics, morals, character, physical and mental health status, and such other information as may be requested by Meridian Institute.

I do hereby authorize all hospitals, and their medical staffs, all health care institutions, educational institutions, persons, peer review organizations, professional liability insurance companies, and other entities with which I have been associated, as well as their respective representatives (collectively "Third Parties") to consult with and release to Meridian Institute , or its respective representatives, any relevant information they may have concerning my qualifications, eligibility and the matters contained in this application.

The authorizations contained herein are irrevocable as long as I am an applicant for Meridian Institute of Surgical Assisting, Inc.

The information contained in this Application is correct and complete in all respects. I understand and agree that any incorrect information in, or omission of, material information from this Application may be grounds for denial of this Application.

I acknowledge that the information developed during the processing of this Application is confidential to the maximum extent permitted by law. A photocopy of this document shall be as effective as the original.

I have read, understand, and agree with the foregoing.

Printed Name of Applicant:

Signature of Applicant:

Date: