STUDENT APPLICATION

1507 County Hospital Road
Nashville, TN 37218
Toll-Free Number: 1-877-954-1500
Local: 615-678-8196 Fax: 615-499-4795

INSTRUCTIONS: In order to be accepted, this Form must be typed or legibly printed. If more space is needed than is provided on the application form, attach additional sheets and make reference to the questions being answered. You are required to provide all information requested or your application may be delayed or suspended. If you have any changes in your employment status, please include a copy of your resume.

How did you hear about Meridian?

REVISED: March, 2014

The SFA Online Program is a distant learning program and, therefore, by its very nature all communications, submissions, and transmissions will be done electronically. In addition, E-mail is considered the official communication between student and school.

Please select the appropriate box:

- ◯ 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.

It is the ongoing policy of our company to afford equal educational opportunity 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.

IDENTIFYING INFORMATION

Gender:

◯ Male
◯ Female

Race:

◯ Caucasian ◯ Hispanic ◯ African American
◯ Other

E-mail:

Maiden Name:

Last Name:

First Name:

Initial:

Birth Date:

Birth Place:

Social Security #:

Home Street Address:

City:

State:

Zip:

Home Telephone:

EMPLOYMENT INFORMATION (Most current to previous)

Current Employer:

Employer Telephone:

Current Employer Address:

Current Position:

Current Supervisor:

From:

To:

Previous Employer Name:

Employer Address:

Employer Telephone:

Position:

Supervisor:

From:

To:

EDUCATION (Chronological)

Institution Name: **Address:** **Telephone:**

Degree/Certificate: **Course:** **From:** **To:**

Institution Name: **Address:** **Telephone:**

Degree/Certificate: **Course:** **From:** **To:**

Institution Name: **Address:** **Telephone:**

Degree/Certificate: **Course:** **From:** **To:**

Applicant hereby makes attestation that I received my high school diploma from:

Institution Name:

Applicant Signature: **Date:**

***All non R.N. and CST students must have completed a basic Anatomy and Physiology course prior to acceptance into Meridian Institute's SFA Online Program. Please complete the following information:

Name of School: **Course:**

Address of School: **Year Obtained:**

Applicant understands that it is their responsibility to obtain a copy of their transcripts from the above-referenced institution, and have them sent to Meridian Institute. Applicant further understands that this must be accomplished prior to their completion of the course. If applicant fails to have their transcripts sent to Meridian Institute, applicant understands they will not be able to graduate.

****All transcripts MUST be certified original copies (photo copies will not be accepted)**

Signature: **Date:**

AFFILIATION AGREEMENT POLICY

Each student, prior to beginning the clinical externship portion of the SFA Online Program, shall secure an affiliation (student training) agreement from the participating hospital. Meridian Institute will provide a sample agreement to the hospital. It is ultimately up to the student to insure follow-through with the hospital.

****All students are responsible for securing their own clinical site and preceptors. Meridian Institute will assist when and where possible, but ultimately the responsibility is that of the students.**

(By signing below, student acknowledges that clinicals will not be counted toward program completion unless an affiliation agreement is on file in Meridian Institute's office prior to beginning this phase.)

Signature: **Date:**

EFFECTIVE POLICY DATE: NOVEMBER 1, 2003

CERTIFICATION:

Are you certified by any organization? (if yes, please indicate below)

◯ Yes ◉ No

Certifying Organization:

Certification Number:

Month and Year Certified:

Expiration Date:

Certifying Organization:

Certification Number:

Month and Year Certified:

Expiration Date:

Certifying Organization:

Certification Number:

Month and Year Certified:

Expiration Date:

Have you ever been denied certification or re-certification?

◯ Yes ◯ No

Has your certification ever been investigated, limited, suspended, placed on probation or stipulations added, or have you ever received a letter of admonition from a certifying board?

◯ Yes ◯ No

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE PROVIDE AN EXPLANATION OF THE DETAILS BELOW.

***PLEASE ATTACH A COPY OF YOUR CURRENT LICENSE AND/OR ANY OTHER STATE LICENSES YOU HOLD AS WELL AS ANY CERTIFICATES YOU HAVE ACQUIRED.* (ONLY REQUIRED IF YOU ARE AN RN, PA OR MD)**

State:

License Number:

Expiration:

CURRENT PROFESSIONAL LIABILITY COVERAGE

Individual Professional Liability Insurance MUST be attained before beginning the clinical phase. If you have any questions regarding this please email info@meridian-institute.edu for more details.

Has your present, or any past professional liability insurance carrier limited, excluded, or refused renewal of any specific function from your coverage?

◯ Yes ◯ No

Have any professional liability suits or claims ever been filed against you?

◯ Yes ◯ No

Are there any suits or claims currently pending?

◯ Yes ◯ No

Have any settlements or judgments been made by or against you in professional liability cases?

◯ Yes ◯ No

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE LIST THE FUNCTIONS (if applicable), WHICH HAVE BEEN EXCLUDED AND PROVIDE A FULL EXPLANATION, INCLUDING THE NAME OF THE CARRIER, THE DATE AND SPECIFIC INFORMATION CONCERNING ANY LIMITATION BELOW.

Have you ever been denied professional liability insurance coverage?

◯ Yes ◯ No

Has your professional liability insurance ever been cancelled, premiums surcharged or renewal refused?

◯ Yes ◯ No

Have any professional liability suits or claims ever been filed against you?

◯ Yes ◯ No

Are there any suits currently pending from previous policies?

◯ Yes ◯ No

Have any settlements or judgments ever been made by or against you in professional liability cases?

◯ Yes ◯ No

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE LIST THE FUNCTIONS (if applicable), WHICH HAVE BEEN EXCLUDED AND PROVIDE A FULL EXPLANATION, INCLUDING THE NAME OF THE CARRIER, THE DATE AND SPECIFIC INFORMATION CONCERNING ANY LIMITATION BELOW.

ALLIED HEALTH PROFESSIONAL CATEGORIES

Please check the appropriate designation for which you are qualified by certification, licensure, or special education:

- ☐ Certified Surgical Technologist
- ☐ Surgical Technologist
- ☐ Registered Nurse
- ☐ Licensed Practical Nurse
- ☐ Certified Surgical First Assistant (CSFA)
- ☐ Other:

Do you wish to request any additional functions not specified in the scope of practice for your professional category listed above?

- ◯ Yes
- ◯ No

IF THE ANSWER TO THE ABOVE IS YES, PLEASE SPECIFY THE FUNCTION(S) AND PROVIDE DOCUMENTATION OF TRAINING AND EXPERIENCE. GIVE A FULL EXPLANATION OF THE DETAILS BELOW.

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 ◯ No

Are there any claims or administrative agency or court cases pending against you?

◯ Yes ◯ No

Have any adverse administrative agency or court decisions ever been rendered against you, or have you ever been found guilty of violating any criminal law (excluding minor traffic violations)?

◯ Yes ◯ No

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE PROVIDE A FULL EXPLANATION OF THE DETAILS BELOW.

CLINICAL REFERENCES

Please supply Meridian Institute with names and addresses of three references. One must be a physician, one an employer, and a peer of your choice who can attest to your clinical competence.

Name: Telephone:

Street Address: City: State: Zip:

Name: Telephone:

Street Address: City: State: Zip:

Name: Telephone:

Street Address: City: State: Zip:

Please sign the Authorization and Release form to be mailed to your listed references. One must be from an employer, one from a non-employer physician, and one from another physician or a peer of your choice who can attest to your clinical competence and adherence to accepted ethics based on their personal knowledge of your professional activities. References to whom you are related or professional partners are not acceptable references.

****It is your responsibility to sign the authorization and release section of this reference form.**

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

https://web.meridian-institute.edu/gedt

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 qualifications 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.

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, or its respective representatives, any relevant information they may have concerning my qualifications, eligibility, and the matters contained in this application.

I further agree that if my professional liability insurance is canceled or modified, Meridian will be notified immediately.

I do hereby release Meridian, and its respective representatives, and all Third Parties who provide information as authorized herein, and grant them immunity from any and all liability or claims I may otherwise have for acts performed in connection with their investigation of this Applicant and my qualifications and their release of information. This Release is in addition to any other immunities or protections for such institutions and individuals provided by law for peer review activities or otherwise.

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: