STUDENT APPLICATON

1507 County Hospital Road

Nashville, TN 37218

Toll Free Number: 1-877-954-1500

Local: 615-678-8196 Fax: 615-499-4795

Instructions:

To be accepted, this form must be typed or legibly printed. You are required to provide all information requested or your application may be delayed or suspended.

How did you hear about Meridian?

The SFA Online Program is a distance learning program and therefore, by its nature all communications, submissions, and transmissions will be completed electronically. Email is the official form of communication between the student and the school. Your submission of this application implies your consent to conduct business electronically with Meridian Institute of Surgical Assisting.

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 any time int the future I must contact the Academic Dean.

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 any time in the future I must contact the Academic Dean.

It is the ongoing policy of Meridian Institute of Surgical Assisting to afford equal educational opportunity to qualified individuals regardless of race, color, religion, sex, national origin, age, physical or mental disability, veteran status and to conform to applicable laws and regulations.

Current License Requirements per state can be found:
https://www.meridian-institute.edu/wp-content/uploads/2023/06/NC_SARA.pdf
Questions concerning licensure should be directed to the specific medical board of these states.

IDENTIFYING INFORMATION

Gender: ○ Male ○ Female

Race: ○ Caucasian ○ Hispanic ○ African American ○ Other

Email: Maiden Name:

Last Name: First Name: Middle Initial:

Social Security Number: - - Birthdate: / /

Birthplace:

Home Address:

City: State: Zip

Home/Cell Telephone:

( ) -

EMPLOYMENT INFORMATION (Most current to previous)

Current Employer: Telephone:

Current Employer Address: ( ) -

City: State: Zip: From: To:

Position:

Previous Employer: Telephone:

( ) -

Position: Supervisor: From: To:

Supervisor:

EDUCATION

Institution: Address:

Degree/Certificate Course: From: To:

Institution: Address:

Degree/Certificate Course: From: To:

HEALTH CARE PROFESSIONAL CATEGORIES

Please check the appropriate designation for which you are qualified by certification, licensure. A copy of your certification or license will be requested during the admission process.

- ☐ Certified Surgical Technologist (CST) Certification Number:
- ☐ Tech In Surgery Certified (TS-C) Certification Number:
- ☐ Registered Nurse License Number:
- ☐ Certified Surgical First Assistant (CSFA) Certification Number:
- ☐ Surgical Technologist (Not Certified)
- ☐ Other:

Have you ever been denied certificate or recertification? ○ Yes ○ No

Has your certification ever been investigated, limited, suspended, placed on probation or stipulations added, or have your 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.

CURRENT PROFESSIONAL LIABILITY COVERAGE

Individual Professional Liability Insurance MUST be attained before beginning Phase III Externship. Questions regarding insurance should be emailed to info@meridian-institute.edu.

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

Graduation Attestation

Applicant hereby makes attestation that I received my high school diploma or General Education Development certificate from the following:

Institution:

Transcripts

Applicant understands that it is their responsibility to provide a copy of their transcripts from that above-referenced institutions. All transcripts must be received prior to completion of the program. If applicant fails to provide the required documents the student will not be able to graduate.

GO TO NEXT PAGE

Gainful Employment Disclosures

Surgical First Assisting – Diploma

This program is designed to be completed in 52 weeks.

The cost of the program is $8745.00 (+$125.00 estimated cost for books) if completed within normal time. There may be additional costs for living expenses. These costs were accurate at the time of posting but may have changed.

Of the students who completed this program within normal time, the typical graduate leaves with $6,768.00 of debt.

For more information about graduation rates, loan repayment rates, and post-enrollment earnings pertaining to this institution and other postsecondary institutions please click here:

https://collegescorecard.ed.gov

GO TO NEXT PAGE

EDUCATIONAL DEBT

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

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

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

Signature: Date:

GO TO NEXT PAGE

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 cancelled or modified, Meridian will be notified immediately.

I do here by 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.

This 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 extend permitted by law. A photocopy of this document shall be as effective as the original.

Printed Name of Applicant:

Signature:

Date: