READING HOSPITAL
SCHOOL OF HEALTH SCIENCES
READING HOSPITAL
Advancing Health. Transforming Lives.

# READING HOSPITAL SCHOOL OF HEALTH SCIENCES

## EMERGENCY MEDICAL TECHNICIAN & RESPONDER PROGRAMS REGISTRATION FORM

**Non-refundable Registration Fee $30.00**

**PROGRAM:** ☐ EMT ☐ EMR **CLASS CHOICE:** ☐ FALL ☐ SPRING ☐ SUMMER

**SITE:** ☐ SOHS ☐ OFFSITE (*Enter Location*) _____

**PERSONAL DATA**

First _____ Middle _____ Last Name _____

Social Security Number _____ Date of Birth ____ / ____ / ____
*(must be at least 16 years old to register)*

Permanent Address _____

City _____ State _____ Zip _____ County _____

Daytime Phone (____) _____ Evening Phone (____) _____

Cell/Mobile Phone (____) _____ Gender: ☐ Male ☐ Female

Email Address _____

**SPONSOR INFORMATION**

***If you are being sponsored by an organization, please enter their information here.***

Organization Name _____

Address _____

City _____ State Zip

**OPTIONAL: What do you consider your ethnic origin?**

***This information will not be used in the admissions process and is for reporting purposes only.***

**Ethnicity:** ☐ Black (non-Hispanic) ☐ Hispanic Latino ☐ White ( non-Hispanic) ☐ Asian/ Pacific Islander
☐ American Indian/Alaskan Native ☐ Indian (from India) ☐ Multi-Racial ☐ Other

**Level of Education:** ☐ High School/GED ☐ Some College ☐ Bachelor's Degree
☐ Master's Degree ☐ Other

Are you a United States Citizen? ☐ Yes ☐ No **Non-US Citizens: Are you a permanent US Resident? ☐ Yes ☐ No

Alien Registration # _____ Visa Classification _____

***Please attach a copy of your alien registration card.***

Statement of Understanding

It is the student's responsibility to provide a valid authorization letter from their sponsor on official company letter head. Upon receipt, the School will bill the sponsor directly for student expenses. This payment is due prior to the start of class and to avoid late payment fees and financial holds. Non-payment of partial or full tuition by the sponsor, for whatever reason, becomes an immediate responsibility of the student.

☐ By checking this box I certify that I have read the above statement and agree to the terms stated herein and acknowledge my registration and/or enrollment will be withdrawn if I do not comply as requested.

**Submit form and non-refundable $30 fee to:**
Reading Hospital School of Health Sciences
EMS Programs
P.O. Box 16052
Reading, PA 19612
***Checks or money orders payable to RHSHS***

**Signature** _____ **Date** ____ / ____ / ____