Registration Form

"Qualified Medication Administration Class"

Student Name: _____ Date: _____

Address: _____ City: _____State: _____ Zip code: _____

Phone No: _____ Emergency Contact Phone No: _____

D/0/B: _____ Colorado ID No: _____ E-Mail Address_____

Do you have currently Q-Map certified? ___ Yes ___No, If yes when does you current certification expire? _____

Have you ever had a Q-Map certification that is now expired? ___ Yes ___ No, if yes when did it expire? _____

What is your highest level of education completed: ___ High School, ___ Trade School, ___ Some College__ College

If none of the above do you have basic math skills: addition, subtraction, multiplication and division?
___ Yes ___No

Current Employer: _____ Phone No: _____

Do you speak and understand English? _____Yes _____No, do you have access to a computer? ___ Yes ___No

I understand the following that all registration forms and payment must be received no later than seven (7) day prior to date of class starting; all payments must be in the form of a money order, electronic payment using Square App or business check payable to the Shared Touch in the amount of $100.00. I will be notified via telephone or email to confirm that registration form was received.

I, also understand that if I_____ decided to attend class and cancel after class has started NO REFUND will be given.

If the instructor has to cancel class I will be notified via e-mail and by telephone. The class will be rescheduled within thirty (30) day. If I, _____ choice not to attend the rescheduled class, a refund will be issued within three (3) business day of the date of the cancellation.

Please return this form to "Shared Touch Inc." 14231 E. 4th Ave 1-101, Aurora CO 80011
Phone 303-261-1110 Fax 303-261-1112

_____

Name Date