VIP NURSING SCHOOL, Inc.
16388 East 14th Street, San Leandro, California 94578
Office: (510) 481-0240; (510) 481-0360: Fax: (510) 481-0242
Web Site: www.vipnursing.net: Email: info@vipnursing.net

A. HOME HEALTH AIDE STUDENT REGISTRATION & ENROLLMENT AGREEMENT

Student Name:_____ **Sex:** Male{ } Female{ }
Last First Middle Initial

Address:_____ _____ _____ _____ _____
Street Apt.# City State ZIP Code

Home Phone:_____ **Work Phone**:_____ **Cell phone:** _____

Social Security No:_____-_____-_____ **Occupation:** _____ **Employer:**_____

Person to Contact In case of Emergency:_____ **Relationship**:_____ **Phone**:_____

Are you at least 16 years of age? Yes{ } No{ } **Date of Birth:** _____ **CA Drivers Lic**._____

Place of Birth: _____ **Color of Eyes:** _____ **Color of Hair:** _____ **Weight:** _____ **Height:** _____

Marital Status: Married{ } Single{ } Separated{ } Divorce{ } **Email:**_____

Do you have a current CNA license? Yes{ } No{ } **Are you 16 years old or older?** Yes{ } No{ }

***There is NO English as a Second Language instruction.**

Have you ever been convicted by any court of law of a crime, other than a minor traffic violation? Yes{ } No{ }
If you answer Yes to this question, You must supply the following information to Department of Health Services in Sacramento:

A. Date and nature of the incident(s)
B. Disposition of the case (Provide Court papers)
C. Current status
D. Letters from your probation Officer (if applicable)
E. Letters of recommendation (if applicable)

EDUCATION

School / Institution	City/State/County	Course	Years Attended	Graduated	Documentation
_____	_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	_____	☐ Yes ☐ No

WORK EXPERIENCE

Employer	City/State/County	Job Title	Dates	Reason for Leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. COMPLAINT NOTICE

"Any questions or problems you may have regarding the catalog that have not been satisfactorily answered by the VIP School, you may direct to:

BUREAU FOR PRIVATE POSTSECONDARY EDUCATION
2535 CAPITOL OAKS DRIVE, Suite 400, Sacramento, California 95833
Mailing Address: P.O. Box 980818, West Sacramento, CA 95798-0818
Toll Free Telephone number (888) 370-7589, or byFAX: (916) 263-1897
Web site: www.bppe.ca.gov

"A student or any member of the public may file a complaint about this institution with the Bureau for Private Postsecondary Education by calling (888) 370-7589 toll-free or by completing a complaint form, which can be obtained on the Bureau's internet web site **www.bppe.ca.gov**

_____ **Signature. Initial & Date**

C. LEGALLY BINDING CLAUSE

"As a prospective student, you are encouraged to review the School Catalog prior to signing an enrollment agreement. You are also encouraged to review the School Performance Disclosure Sheet, which must be provided to you prior to signing enrollment. _____

(Student Signature/Initial & Date)

This agreement is a legally binding instrument when signed by the student and accepted by the school. Your signature on this agreement acknowledges that you have been given reasonable time to read and understand it and that you have been given: (a) a written statement of the refund policy including examples of how it applies and: (b) a School catalog including a description of the course or educational services, (c) School Performance Fact Sheet, and the program or course of instruction which are likely to affect your decision to enroll. Immediately upon signing this agreement, you will be given a copy of it to retain.

"I certify that I have received the Catalog, School Performance Fact Sheet, and information regarding completion rates, license examination passage rates, and salary or wage information included in the School Performance Disclosure sheet." _____

(Student Signature/Initial & Date)

D. THIS AGREEMENT IS FOR:

The **HOME HEALTH AIDE TRAINING** consists of 150 clock hours of training. VIP offers Day and Evening classes. The **Day Class is 5 days** in length, **Monday through Friday from 8:00am-5:00pm Theory & Skills Laboratory and Clinical Externship.** The **Evening Class is 9 days** in length, **Monday through Friday from 5pm–10pm Theory/Skills Laboratory and Clinical Externship.** The student will receive completion for Home Health Aide course when he/she pass the final exams and show a satisfactory return demonstration in the Skills laboratory and during clinical externship, he/she then become a Certified Home Health Aide.

Please check: ☐ **Day Class** ☐ **Evening Class**

START DATE: _____ **SCHEDULED COMPLETION DATE:** _____

THEORY CLASS & SKILLS LAB. LOCATION:	**CLINICAL TRAINING LOCATION:**
VIP NURSING SCHOOL 16388 East 14th Street, San Leandro, CA 94578 Office: (510) 481-0240 Fax: (510) 481-0242	BAY POINT HEALTHCARE CENTER 442 SUNSET BLVD., HAYWARD, CA 94541 Telephone: (510) 581-3382

NOTE: In Clinical training, the ratio of instructor to students is 1:15

E. "NOTICE CONCERNING TRANSFERABILITY OF CREDITS AND CREDENTIALS EARNED AT OUR INSTITUTION"

"The transferability of credits you earn at VIP Nursing School is at the complete discretion of an institution to which you seek to transfer. Acceptance of the diploma, or certificate you earn in Vocational Nursing, Nursing Assistant, or Home Health Aide respectively is also at the complete discretion of the institution to which you may seek to transfer. If the credits or diploma, or certificate that you earn at this institution are not accepted at the institution to which you seek to transfer, you may be required to repeat some or all of your coursework at that institution. For this reason you should make certain that your attendance at this institution will meet your educational goals. This may include contacting an institution to which you seek to transfer after attending VIP Nursing School to determine if your credits or diploma or certificate will transfer."

_____**Signature. Initial & Date**

F. STUDENT'S RIGHT TO CANCEL

"You have the right to cancel this enrollment agreement and obtain a refund. You may cancel this agreement and receive a refund of charges paid through attendance at the First (1ST) class session or on the 2nd Day for Day Class, OR 5th Day for Eve Class after the enrollment, whichever is later. and provide a written notice to:"

Josephine Dondriano RN, CNA/HHA Program Director
VIP Nursing School, Inc.
16388 East 14th Street, San Leandro, California 94578
Office: (510) 481-0240; 481-0360
Fax: (510) 481-0242
Email: josie@vipnursing.net

_____ **Signature. Initial & Date please**

G. CANCELLATION. WITHDRAWAL, and REFUND INFORMATION:

Should you be terminated by the school, or decides to cancel the enrollment agreement and obtain a refund of charges paid through attendance at the First (1ST) class session or on the 2nd Day for Day Class, OR 5th Day for Eve Class after the enrollment, whichever is later. The amount retained for the non-refundable registration fee may not exceed $50.00 for HOME HEALTH AIDE course. In addition, the student may withdraw from a course after instruction has started and receive a pro rata refund and paid $350.00 tuition, the student would receive a refund of $ as illustrated in the **hypothetical example below based from the First (1ST) class session or on the 2nd Day for Day Class, OR 5th Day for Eve Class after the enrollment, whichever is later** This institution has a refund policy for the return of unearned institutional charges if the student cancels an enrollment agreement or withdraws during a period of attendance. **The refund policy for students who have completed 60 percent or less of the period of attendance shall be a pro rata refund.**

Cancellation must be made in writing, either in person or by mail.

All monies, **except the non-refundable registration fee,** will be refunded if the applicant is not accepted by the school.

All monies will be refunded if the **student cancels on, or before, the First (1ST) class session or on the 2nd Day for Day Class, OR 5th Day for Eve Class after the enrollment, whichever is later.**

Refunds will be made within thirty (30) days after receipt of cancellation notice.

$350.00 amount paid for instruction	**x**	**24 clock hours of instruction received & completed / 40-clock hours of instruction for which the student has paid**	**=**	**$350.00 tuition paid - $210.00 (based 60% of completed instruction received) $140.00 REFUND AMOUNT**

_____ **Signature. Initial & Date please**

H. STUDENT TUITION RECOVERY FUND INFORMATION:

"You have the rights and responsibilities with respect to the Student Tuition Recovery Fund (STRF)."

"You must pay the State-Imposed assessment for the STRF if all of the following applies to you:"

1. You are a student in an educational program, who is a California resident, or are enrolled in a residency program, and prepay all of part of your tuition either by cash, guaranteed student loans, or personal loans, and
2. Your total charges are not paid by any third-party payer such as an employer, government program or other payer unless you have a separate agreement to repay the third party.

"You are not eligible for protection from the STRF and you are not required to pay the STRF assessment if either of the following applies to you."

1. You are not a California resident, or are not enrolled in a residency program, or
2. Your total charges are paid by a third party, such as an employer, government program or other payer, and you have no separate agreement to repay the third party."

_____ **Signature. Initial & Date**

"The State of California created the STRF to relieve or mitigate economic losses suffered by students in educational programs who are California residents, or are enrolled in a residency program attending certain schools regulated by the Bureau for Private Postsecondary Education."

You may be eligible for STRF if you are a California resident or are enrolled in a residency program, prepaid tuition, paid STRF assessment, and suffered an economic loss as a result of any of the following:

1. The school closed before the course of instruction was completed.
2. The school's failure to pay refunds or charges on behalf of a student to a third party for license fees or any other purpose, or to provide equipment or materials for which a charge was collected within 180 days before the closure of the school.
3. The school's failure to pay or reimburse loan proceeds under a federally guaranteed student loan program as required by law or to pay or reimburse proceeds received by the school prior to closure in excess of tuition and other costs.
4. There was a material failure to comply with the Act or the Division within 30-days before the school closed or, if the material failure began earlier than 30-days prior to closure, the period determined by the Bureau.
5. An inability after diligent efforts to prosecute, prove, and collect on a judgment against the institution for a violation of the Act."

However, no claim can be paid to any student without a social security number or a taxpayer identification number.

I. REGISTRATION, TUITION FEES and REQUIREMENTS EXPENSES:

HOME HEALTH AIDE TRAINING PROGRAM COURSE FEE:

$350.00 TUITION FEE

+ $50.00 NON-REFUNDABLE REGISTRATION FEE UPON ENROLLMENT

$400.00 TOTAL REGISTRATION, TUITION FEES _____(Student Initial/Date)

MANDATORY REQUIREMENTS:

+ $50.00 PROVIDING HOME CARE BY LEAHY FOR HOME CARE AIDES TEXTBOOK (on 1st Day of Session)

PROOF OF PHYSICAL EXAM WITH TB TEST (Bring on 1st Day of Session)

$50.00 TOTAL REGISTRATION & REQUIREMENTS _____(Student Initial/Date)

OPTIONAL ITEMS:

+ $32.00 Blood Pressure Machine & Stethoscope

+ $15.00 Safety Gait Belt

$47.00 Optional Items Total

Registration ($50.00), Tuition ($350.00), & Requirements ($50.00) (Total = $450.00

Registration Fee ($50.00), Tuition ($350.00), & Requirements ($50.00) & Optional Items ($47.00) Total = $497.00

_____(Student Initial/Date)

_____Signature. Initial & Date

J. SCHEDULE OF INSTALLMENT PLANS:

Installment is available without any interest as per installment plan as described below. Tuition fee must be paid in full on or prior to Final examination. **Installment must be paid on the first (1st) to the 2nd Day for Day Class, or 5th Day for Eve Class, otherwise a 5% late fee is charged for late payments, i.e. 5% of the installment due.**

FIRST PAYMENT	SECOND PAYMENT
$175.00	$175.00
On the First week of the Session Date:_____	By End of the Session Date:_____
_____ (Student Initial)	_____(__Student Initial)

K. PHYSICAL EXAMINATION:

Home Health Aide Course Applicants:

Please have the attached Physical Examination form and TB Test Results completed and **submit it with this Student Registration and Enrollment Agreement on the first day of the class prior to first day of Clinical.**

_____Signature. Initial & Date please

L. HOME HEALTH AIDE STUDENT APPLICANT'S SIGNATURES:

"PRIOR TO SIGNING THIS ENROLLMENT AGREEMENT, YOU MUST BE GIVEN A CATALOG OR BROCHURE AND A SCHOOL PERFORMANCE FACT SHEET, WHICH YOU ARE ENCOURAGED TO REVIEW PRIOR TO SIGNTHIS AGREEMENT. THESE DOCUMENTS IMPORTANT POLICIES AND PERFORMANCE DATA FOR THIS INSTITUTION. THIS INSTITUTION IS REQUIRED TO HAVE YOU SIGN AND DATE THE INFORMATION INCLUDED IN THE SCHOOL PERFORMANCE DISCLOSURE SHEET RELATING TO COMPLETION RATES, PLACEMENT RATES, AND SALARIES OR WAGES, PRIOR TO SIGNING THIS AGREEMENT." _____

(Student Signature/Initial & Date)

"I CERTIFY THAT I HAVE RECEIVED THE CATALOG, SCHOOL PERFORMANCE FACT SHEET, AND INFORMATION REGARDING COMPLETION RATES, PLACEMENT RATES, LICENSE EXAMINATION PASSAGES RATES, AND SALARY OR WAGE INFORMATION INCLUDED IN THE SCHOOL PERFORMANCE DISCLOSURE SHEET, AND HAVE SIGNED, INITIALED, AND DATED THE INFORMATION PROVIDED IN THE PERFORMANCE DISCLOSURE SHEET.

_____ **(Student Signature/Initial & Date)**

" I UNDERSAND THAT THIS IS A LEGALLY BINDING CONTRACT. MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ, UNDERSTOOD, AND AGREED TO MY RIGHTS AND RESPONSIBILITIES, AND THAT THE INSTITUTION'S CANCELLATION AND REFUND POLICIES HAVE BEEN CLEARLY EXPLAINED TO ME. _____ **(Student Signature/Initial & Date)**

THIS AGREEMENT IS NOT OPERATIVE UNTIL THE STUDENT MAKE AN INITIAL VISIT TO THE OFFICE AND RECEIVES THOROUGH TOUR, AND ATTENDS THE FIRST CLASS OF INSTRUCTION.

_____ _____

Signature of Student **Date of Visit or Tour of the School**

M. SCHOOL OFFICIAL'S SIGNATURES

I certify that VIP NURSING SCHOOL, INC. has met the disclosure requirements of Education Code Section 94312 of the Private Postsecondary Reform Act of 1989.

THIS AGREEMENT IS ACCEPTED BY:

_____ _____ _____ _____

Signature of Program Director **Date** **Signature of School Admission** **Date**

"NOTICE"

"YOU MAY ASSERT AGAINST THE HOLDER OF THE PROMISSORY NOTE YOU SIGNED IN ORDER TO FINANCE THE COST OF THE EDUCATIONAL PROGRAM ALL OF THE CLAIMS AND DEFENSES THAT YOU COULD ASSERT AGAINST THIS INSTITUTION, UP TO THE AMOUNT YOU HAVE ALREADY PAID UNDER THE PROMISSORY NOTE."

N. SIGNATURE PAGE

MY SIGNATURE BELOW CERTIFIES THAT I HAVE HAD A COMPLETE ORIENTATION OF THE RULES AND REGULATIONS OF VIP NURSING SCHOOL, A TOUR OF THE SCHOOL, COPY OF SCHOOL CATALOG, AND SCHOOL PERFORMANCE DISCLOSURE SHEET.

_____**Signature. Initial & Date**

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STUDENT PERSONAL HEALTH QUESTIONAIRE

Name: _____ _____ _____
Last **First** **Middle Initial**

Address: _____ _____ _____ _____ _____
Street Address **Apt. #** **City** **State** **ZIP Code**

Phone: ( ) _____ ( ) _____ ( ) _____
Home Phone **Work Phone** **Cell Number**

Sex: ( ) Male ( ) Female **Date of Birth:** _____ **Place of Birth:** _____

In case of emergency, who should we contact: _____ **Tel:** _____

Have you had or do you have any of the following? **(Check YES or NO after each question.)**

	YES	NO		YES	NO		YES	NO
Dizziness			Hernia (rupture)			Cancer or tumors		
Frequent headaches			Stomach ulcers			Asthma		
Fainting spells			Pneumonia			Hay fever		
Chest pains			Pleurisy			Diabetes		
Heart palpitation			Bronchitis			Nervous breakdown		
Chronic Cough			Tuberculosis			Rheumatism		
Shortness of breath			Kidney Stones			Arthritis		
Allergies			Nephritis			Injuries		
Seizures			Malaria			Operations		
Hypertension			Rheumatic fever			Back injury		
Jaundice			Paralysis			Other serious illness		

Injuries, operations, serious illness, please explain: _____
_____

Date of Last Visit to Physician:_____ **Reason**: _____

Date of Last Hospitalization: _____ **Reason**: _____

Have you received any disability payments or compensation for the injury? If so, please explain:
_____

_____

Do you have any physical problem which may interfere with your Clinical Training with the School? If so, please explain:_____

_____

I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND GIVE THE EXAMINING PHYSICIAN PERMISSION TO SUBMIT A COPY OF THIS REPORT TO VIP Nursing School, Inc.

_____ _____
Student's Signature **Date**

Records must be kept for five (5) years. VIP School

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PHYSICAL MEDICAL EXAMINATION FORM:

Name: _____ **Sex:** Male{ } Female{ }
Last Name First Name Middle Initial

Address: _____ _____ _____ _____ _____
Street Name Apt.# City State ZIP Code

Home Phone:(____)_____ **Work Phone**:(____)_____ **Cell**:(____)_____

To Be Completed by Examining Physician or by a Nurse Practitioner: Must be submitted prior to the First (1st) day of Clinical training.

Current complaints or disabilities to the student's education in the Nursing Assistant/Home Health Aide applicant:

_____

_____

Medications used: Prescription and Over-the-Counter:

Name of the Drug	Reason	Frequency
_____	_____	_____
_____	_____	_____

Significant medical history, accidents, deformities, surgeries, back problems, hepatitis, etc.:

_____

_____

Examination, comments and findings of examination: _____

REQUIRED SCREENING:

PPD: Should be done within 6 months of patient care by the student is required for the Nursing Assistant/Home Health Aide applicant.

Date of PPD: _____**Results:** _____ **Chest X-ray (If PPD is Positive). Date:** _____ **Result:**_____**for T.B.**

Date of Hepatitis Screen: _____**Results:** _____ **(Not Applicable for Nursing Assistant applicant)**

The above named patient has no communicable or disabling disease nor any health condition that would create a hazard to himself/herself, fellow employees or to patients at this time. He/She is able to perform the physical activities required for the Nursing Assistant program or home Health Aide for which the individual is applying.

_____ _____ _____
Print Examiner's Name **Examiner's Signature** **Date**

_____ _____ _____ _____ _____
Address Street City State Zip Code Phone Number

I give permission to release a copy of this physical examination form to the contracted clinical facility.

_____ _____
Student's Signature **Date** Records must be kept for 5 (five) years. VIP School