Falcon Institute of Health and Science

Registration Form for Practical Nurse Education Program

Phone: 610- 253-2527 Fax: 610-438-0201 www.falconihs.com

Personal Information:

Name: _____ Date of Birth: _____

Telephone: _____

Email: _____ Gender: ☐ Male ☐ Female

Current Address: _____

City: State: Zip Code: _____

Emergency Contact: Name: _____ Relationship_____ Telephone: _____

Are you a citizen of US: ☐ Yes ☐ No If No, please submit a copy of your green card at the time of registration.

Social Security Number: _____

Is your Social Security number issued after June 24, 2011? ☐ Yes ☐ No
If yes, please fill out the Social Security Release and Verification form issued by the Social Security Administration.

- Ethnic background: ☐ Caucasian ☐ African American ☐ Latino ☐ Asian ☐ American Indian ☐ Alaskan ☐ Other

- *Provision of this information is voluntary and will not affect consideration of your application. The response is used solely for compliance with civil rights laws.*

Education:
Do you have a high school diploma or GED? ☐ Yes ☐ No Year of graduation _____

Name of high school/GED testing site: _____

City: _____ State_____

Did you attend an educational institution beyond high school? ☐ YES ☐ NO

If yes, please enter the name of the name of institution(s): _____
Year(s) attended _____

Did you graduate from this institution (s)? ☐ YES ☐ NO Field of Study_____

**I do hereby authorize the disclosure to Falcon Institute of Health and Science any information that may be requested conserving my record of arrest/conviction.*

Applicant Signature _____ Date:_____

Signature of School Representative_____ Date:_____

**The registration fee is fully refundable if the student requests cancellation within 5 calendar days of submitting the registration fee. The registration fee is nonrefundable after 5 calendar days.*