



3540 Forest Hill Blvd Suite 101
West Palm Beach FL 33406

561-433-3940 office
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ENROLLMENT AGREEMENT

THIS AGREEMENT, TOGETHER WITH THE PROGRAM CATALOG
CONSTITUTES A BINDING CONTRACT

BETWEEN THE STUDENT, PBCMSS INSTITUTE FOR LEARNING

READ APPLICATION THOROUGHLY BEFORE ANSWERING QUESTIONS

STUDENT INFORMATION

Name: _____

Address: _____

Street Address

City/State

Zip/Postal Code

EMPLOYER INFORMATION (IF APPLICABLE)

Name: _____

Address: _____

Street Address

City/State

Zip/Postal Code

Telephone: _____ Contact: _____

PROGRAM TITLE: COMMUNITY HEALTH WORKER CARE COORDINATION

Credential Issued: Certificate of Completion

Class Schedule: _____

Start Date: _____ Anticipated Program Completion Date: _____ Hours of Training: _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

TUITION: \$999.00 (includes registration fees, learning materials and supplies)

METHODS OF PAYMENT

- Full payment at time of signing enrollment agreement.
- 25% of Tuition at time of signing enrollment agreement with balance paid prior to program start date by any combination of funds from other sources including local grants or scholarships.
- No interest is charged by the school.
- No additional fees will be charged.

RESPONSIBLE PARTY FOR TUITION PAYMENT

___ STUDENT ___ Local Scholarship/Grant Program

There are no carrying charges, interest charges, or service charges connected or charged with tuition payment. Contracts are not sold to a third party at any time. Cost of class is included in the price cost for the goods and services.

ACKNOWLEDGEMENT

This contract contains the entire agreement between PBCMSS Institute for Learning and _____, and no further modification or representation except as herein expressed in writing will be recognized.

Student must be 18 years of age for admission to PBCMSS CHW Care Coordination.

NOTICE TO PROSPECTIVE STUDENTS: DO NOT SIGN THIS CONTRACT BEFORE YOU HAVE READ IT OR IF IT CONTAINS ANY BLANK SPACES. ALL SIGNERS HAVE RECEIVED AND READ A COPY OF THE BINDING DOCUMENT AND CATALOG.

Signature of Applicant

Date (MM/DD/YYYY)

*Signature of PBCMSS Institute for Learning
Official*

Date (MM/DD/YYYY)



REFUND POLICY

WHEN A STUDENT WITHDRAWS

The amount of Program tuition (*including program enrollment, learning materials and supplies*) refund earned is based on the amount of time the student spent in academic attendance. The amount of funds refunded to the student will be based on the last day of recorded attendance. The tuition fee refund is the complete number of hours for the program minus the number of hours attended. The Student Withdrawal Date (as described above) is used in the following circumstances:

CANCELLATION AND INSTITUTIONAL REFUND POLICY

Should a student's enrollment be terminated or cancelled for any reason, all refunds will be made according to the following refund schedule:

1. Cancellation can be made in person, by telephone, electronic mail, by Certified Mail or by termination.
2. All monies will be refunded if the PBCMSS Institute for Learning does not accept the applicant or if the student cancels within three (3) business days after signing the enrollment agreement and making initial payment.
3. Cancellation after the third (3rd) Business Day, but before the first class, results in a refund of all monies paid.
4. A student canceling after attendance has begun through 50% completion of the program will result in a Pro-Rata refund computed based on the number of hours completed to the total program hours.
5. Cancellation after completing more than 50% of the program will result in no refund.
6. The termination date for refund computation purposes is the last date of actual attendance by the student unless earlier written notice is received.
7. Termination/Withdrawal Date: In calculating the refund due to a student, the last date of actual attendance by the student is used in the calculation unless earlier written notice is received.
8. Refunds will be mailed within 30 days of termination of students' enrollment or receipt of Cancellation/Withdrawal Notice from student via check.

GROUNDINGS FOR TERMINATION

Student agrees to comply with the rules and policies and understand that PBCMSS shall have the right to terminate this contract and enrollment at any time for violation of rules and policies as outlined in the catalog. Student understands that PBCMSS Institute for Learning reserves the right to modify the rules and regulation, and that will be advised of any and all modifications.

PROGRAM COMPLETION REQUIREMENTS

Student understands that in order to receive a certificate of completion from PBCMSS Institute for Learning he/she must successfully complete the required number of scheduled clock hours as specified in the catalog and on the Student Enrollment Agreement and satisfy all financial obligations to PBCMSS Institute for Learning. Students must also demonstrate content comprehension through average post session evaluation score of 70% or more.

CAREER SERVICES

Student understands that PBCMSS Institute for Learning has not made and will not make any guarantees of employment or salary upon completion. PBCMSS Institute for Learning will provide student with placement assistance, which will consist of identifying employment opportunities and advising me on appropriate means of attempting to realize these opportunities.



PERSONAL INFORMATION **DATE** _____

STUDENT NAME _____

WORK PHONE NO. _____ CELL PHONE NO. _____ EMAIL _____

WHAT LANGUAGE(S) DO YOU SPEAK? ENGLISH SPANISH CREOLE OTHER

WHY WOULD YOU LIKE TO PARTICIPATE IN THIS PROGRAM?

WHAT DO YOU EXPECT TO TAKE AWAY FROM THIS COURSE?

EDUCATION	NAME AND LOCATION OF SCHOOL	*DEGREE	*GRADUATION YEAR?	*MAJOR OR AREA OF CONCENTRATION
HIGH SCHOOL				
COLLEGE				
GRADUATE SCHOOL				

PROFESSIONAL EXPERIENCE

CURRENT POSITION _____ EMPLOYER _____ TIME PERIOD _____

DESCRIPTION _____

PREVIOUS POSITION _____ EMPLOYER _____ TIME PERIOD _____

DESCRIPTION _____

PATIENT AND CARE TEAM INTERACTION

If you are currently employed, how many hours per week do you have direct patient contact (phone, in person, email, text)? Please describe the interaction.

If you are currently employed, how many hours per week do you have direct contact with a medical provider? Please describe the interaction.

If you are currently employed, how many hours per week do you have direct contact with other care team members? Please describe the interaction.

Are there other areas of Medical Interest or experience that you would like us to know about? If so, please describe them.