MISSION HOSPITALS

Application for the Healthcare Advancement Training Program (HAT)

This request for information is confidential and will be used solely in determining your eligibility for the Healthcare Advancement Training Program (HAT). This information will also help program officials better serve you after you are placed in one of our basic educational components.

Name: _____ Date: _____
First Middle Initial Last

Date of Birth: _____ Social Security Number: _____

Address: _____ _____
Street/P.O. Box Apt# City State Zip Code County

Home Phone Number: _____ Work Phone Number: _____ Alternate Phone Number: _____

Gender: ف Male ف Female

Race: ف Hispanic ف African American ف Ukrainian/Russian ف Other: _____

Are you a citizen of the United States? ف Yes ف No
Do you have a disability (optional)? ف Yes ف No
Do you have limited English speaking ability? ف Yes ف No

Education:

Do you have a high school diploma or a GED? ف Yes ف No (If *No*, what was the last grade completed?) _____
Do you have a college degree? ف Yes ف No [ ] 2-year [ ] 4-year Field of Study? _____
Can you read the newspaper? ف Yes ف No
Are you willing to study at home? ف Yes ف No
What is your work section at Mission Hospitals? _____ What are your work hours? _____

Student Goals: *Please check all applicable goals*

ف Learn to read
ف Improve Basic Reading and Math skills
ف Learn English
ف Obtain U.S. Citizenship
ف Improve oral/written communication skills
ف Improve basic skills for personal satisfaction
ف Obtain a better job or obtain a job promotion
ف Attain a GED
ف Other: _____

I certify that the information provided on this application is true to the best of my knowledge. I understand that my signature on this form means that I am willing to enroll in the HAT Program, and if qualified, attend basic educational or English As A Second Language class to improve my skill and achieve my personal goals.

_____ _____
Signature *Date*