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MYCAA CLINICAL MEDICAL ASSISTANT COURSE ENROLLMENT AGREEMENT

(PLEASE PRINT, MAIL, EMAIL OR FAX REGISTRATION FORM TO ABOVE ADDRESS)

NAME: ___ _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

PHONE NUMBER: _____(H) _____(C)

E-MAIL: _____

LOCATION ATTENDING _____START DATE _____

ONE TIME FULL PAYMENT

MYCAA

_____**$3,200** Clinical Medical Assisting (CCMA Certification)
_____**$5,800** Medical Assisting (CCMA, CMA, CPB Certifications)

CONTRACT AGREEMENT

I, _____ hereby agree to the above mentioned terms of the program.

I have read and understand the STANDARDS OF PROGRESS for this course and agree to its terms.

SIGNATURE:_____ DATE: _____