ACADEMY of MEDICAL PROFESSIONS

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MYCAA CMAA COURSE ENROLLMENT AGREEMENT

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

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

PHONE NUMBER: _____(H) _____(C)

E-MAIL: _____

I have earned a High School Diploma or Equivalent (GED, HiSET, etc.) (Initial here) _____

LIVE (Webex, see start dates on calendar) START DATE:_____

ONLINE (watching prerecorded classes) START DATE:_____

MYCAA: Indicate course option below:

_____ **$3,200** Medical Office Specialist (CMAA & Billing Certificate)
$6,300 Medical Professional (CMAA, CPC-A, Billing Certificate)

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: _____