ACADEMY *of* MEDICAL PROFESSIONS

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MYCAA MEDICAL TRANSCRIPTION 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: ____

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

ONLINE (watching prerecorded classes) START DATE:_________________

ONE TIME FULL PAYMENT

MYCAA

_____ **$2,650** Medical Transcription All-Inclusive program

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: __________________