ONLINE VIDEO TRAINING MODULE REGISTRATION

Date:_____

Last Name | First | MI | Date of Birth | Social Security Number | Email Address

Mailing Address | City | State | Zip Code | Home Phone # | Work Phone #

Name of Course	*Start Date*	*Course Prefix*	*Course Number*	*Synonym Number*	*Section Number*	*Campus*	*Tuition*	*Lab Fees*	*Other Fees*
New Medications Released During 2004	**---**	**HPRS**	**3002**	**----**	**----**	**ISPD**	**$10**	**---**	**---**
I would like to receive my certificate of completion by: o Mail to: _____ o Fax to: (_____) _____-_____ o Picking it up at the ACC - 5930 Middle Fiskville Rd. location (4th Floor).									
						Subtotal	$10.00	---	---
						Total Fees & Tuition (payment due at time of registration)	**$10.00**		

Please Check One: (*for State Reporting Purposes*)

Ethnicity:
- O Hispanic/Latino
- O Black/African American
- O Asian
- O American Indian/Alaskan Native
- O Native Hawaiian/Pacific Islander
- O White
- O Other

Gender:
- O Female
- O Male

Students with disabilities that need accommodations should contact ACC's Office for Students with Disabilities at (512) 223-2026 or TTY 512-223-2019 or visit www.austincc.edu/osd for more information.

Family Education Rights and Privacy Act of 1974

The following statement concerning student records maintained by Austin Community College is published in compliance with the Family Education Rights and Privacy Act of 1974. The release of information to the public without the consent of the student will be limited to that designated as directory information. Directory information includes name, address, telephone number, date and place of birth, major field of study, participation in activities, dates of attendance, degrees, certificates and awards, and name of most previous educational institution attended. Any student objecting to the release of all or any portion of such information must notify the Office of Admissions in writing and the restriction will remain in effect until revoked by the student.

I authorize Austin Community College to release all information necessary, including my name and Social Security number, to the Texas Workforce Commission, for purposes of tracking employment and wages. This compiled employment and wage information will be provided only to local Workforce Development Boards and will not be released to any other organization or person without my written approval. I understand that the release of these records is required to meet federal program reporting requirements in the process of securing funding for certain qualified students enrolled in Continuing Education Workforce programs and will be kept strictly confidential.

_____

Signature **Date**

Complete the area below if using a credit card to register by Fax (512) 223-7030 or by mail. We accept Visa, Master Card and Discover.

Circle one: VISA Master Card Discover Expiration Date: _____ Amount charged $ _____

Name on card: _____ Signature: _____

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

No receipt will be mailed, please call if you need confirmation of your class registration. Insurance fees are non-refundable after first class day.

Send your completed Registration Form (check or credit card), Post-Test, Evaluation, and payment to:

Austin Community College, Health Professions Institute

Attn: Online Nursing Videos, 5930 Middle Fiskville Rd., Austin, TX 78752, Fax: 512-223-7030