



Referred by: _____

REVISED 3/19/2008

Student Application

PO Box 758 Joelton TN 37080-0758
Toll-Free Number: 1-877/954-1500
Local: 615/746-6763; Fax 615/746-6765

INSTRUCTIONS: In order to be accepted, this Form must be typed or legibly printed. If more space is needed than is provided on the application form, attach additional sheets and make reference to the questions being answered. You are required to provide all information requested or your application may be delayed or suspended. If you have any changes in your employment status, please include a copy of your resume.

- Male It is the ongoing policy of our company to afford equal educational opportunity to qualified individuals regardless of their race, color, religion, sex, national origin, age, physical or mental handicap, veteran status, or because they are disabled veterans, and to conform to applicable laws and regulations.
- Female

PRINTED NAME	SIGNATURE	DATE
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IDENTIFYING INFORMATION Email Address: _____

Last Name	First Name	Initial	Maiden Name
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Birth date	Birth place	Social Security Number
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Home Address	City	State	Home Telephone #
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Employed By	Work Telephone #
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Employers Address _____

EMPLOYMENT (Most current to previous)

Employer Name	Address	Telephone #
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Position	Supervisor	From (mmyy)	To (mmyy)
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Employer Name	Address	Telephone #
---------------	---------	-------------

Position	Supervisor	From (mmyy)	To (mmyy)
----------	------------	-------------	-----------

Employer Name	Address	Telephone #
---------------	---------	-------------

Position	Supervisor	From (mmyy)	To (mmyy)
----------	------------	-------------	-----------

EDUCATION (Chronological)

Institution Name	Address	Telephone #
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Degree/Certificate	Dates of Attendance	Course
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Institution Name	Address	Telephone#
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Degree/Certificate	Dates of Attendance	Course
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Institution Name	Address	Telephone #
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Degree/Certificate	Dates of Attendance	Course
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Meridian Institute of Surgical Assisting

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Anatomy and Physiology Requirement

***All non R.N. and CST students must have completed a basic Anatomy and Physiology course prior to acceptance into Meridian's SFA Online Program. Please complete the following information:

Name and Address of School: _____

Name of Course: _____

Year Obtained: _____

I, _____, understand that it is my responsibility to obtain a copy of my transcripts from the above-referenced institution, and have them sent to Meridian Institute. I further understand that this must be accomplished prior to my completion of the course. If I fail to have my transcripts sent to Meridian Institute I understand I will not be able to graduate.

Signature

Date

**ALL TRANSCRIPTS MUST BE CERTIFIED ORIGINAL COPIES
(PHOTO COPIES WILL NOT BE ACCEPTED)**

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Affiliation Agreement Policy

Each student, prior to beginning the clinical preceptorship portion of the **SFA Online** program, shall secure an affiliation (student training) agreement from the participating hospital.

Meridian will provide a sample agreement to the hospital. It is ultimately up to the student to insure follow-through with the hospital.

Signature

Date

(By signing above, student acknowledges that clinicals will not be counted toward program completion unless an affiliation agreement is on file in Meridian's office prior to beginning this phase.)

Effective Policy Date: November 1, 2003

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CPR Certification

BLS/C Expiration Date: _____ ACLS Expiration Date: _____

Membership/Affiliations

Please check which apply:

Association Surgical Technologists - *Englewood, CO 80112 (303) 694-9130*

Membership #: _____ Expiration Date: _____

Association of Operating Room Nurses - *Denver, CO 80231 (303) 755-6300*

Membership #: _____ Expiration Date: _____

Community Affiliations

Institutional Appointments and Surgical Privileges

- YES NO Has your application for privileges at any Hospital ever been denied?
- YES NO Have you ever resigned from or relinquished privileges at any Hospital or Healthcare institution?
- YES NO Has your allied health professional privileges at any hospital been denied, been limited, suspended, revoked, not renewed or subjected to probationary or specified restrictions, or has any investigation been instituted or recommended by any hospital, medical staff committee or governing board?

**IF THE ANSWER TO ANY OF THE ABOVE IS YES,
PLEASE PROVIDE AN EXPLANATION OF THE DETAILS
ON A SEPARATE SHEET AND ATTACH.**

Certification

Please attach copy of Certificate(s)

Are you certified by any organization? YES NO (if yes, please indicate below)

Certifying Organization Certification #

Month and Year Certified Expiration Date

Certifying Organization Certification #

Month and Year Certified Expiration Date

Certifying Organization Certification #

Month and Year Certified Expiration Date

YES NO Have you ever been denied certification or re-certification?

YES NO Has your certification ever been investigated, limited, suspended, placed on probation or stipulations added, or have you ever received a letter of admonition from a certifying board?

**IF THE ANSWER TO EITHER OF THE ABOVE IS YES,
PLEASE PROVIDE A FULL EXPLANATION OF THE DETAILS
ON A SEPARATE SHEET AND ATTACH.**

Licensure

PLEASE ATTACH A COPY OF YOUR CURRENT LICENSE AND/OR ANY OTHER STATE LICENSES YOU HOLD.

Type of License	State	License #

Month and Year Licensed	Expiration Date

Current Professional Liability Coverage

Professional Liability Insurance must be attained before beginning the clinical phase. Please attach a copy of Certificate

- Insured through employer Insured independently

Carrier Name	Address

Policy #	Expiration Date

Coverage Amount: _____

- YES NO Are you applying for any functions not covered by your liability policy?
- YES NO Has your present, or any past professional liability insurance carrier limited, excluded, or refused renewal of any specific function from your coverage?

If the answer to either of the above is yes, please list the functions which have been excluded and provide an explanation on a separate sheet, including the name of the carrier, the date and specific information concerning any limitation.

- YES NO Have any professional liability suits or claims ever been filed against you?
- YES NO Are there any suits or claims currently pending?
- YES NO Have any settlements or judgments been made by or against you in professional liability cases?

IF THE ANSWER TO EITHER OF THE ABOVE IS YES, PLEASE PROVIDE A FULL EXPLANATION OF THE DETAILS ON A SEPARATE SHEET AND ATTACH.

Previous Professional Liability Insurance

Carrier Name Address

Policy # Expiration Date

Carrier Name Address

Policy # Expiration Date

YES NO Have you ever been denied professional liability insurance coverage?

YES NO Has your professional liability insurance ever been cancelled, premiums surcharged or renewal refused?

**IF THE ANSWER TO EITHER OF THE ABOVE IS YES,
PLEASE STATE WHEN AND BY WHICH COMPANY BELOW.**

Carrier Name Date of Policy Cancellation/Denial

Carrier Name Date of Policy Cancellation/Denial

YES NO Have any professional liability suites ever been filed against you?

YES NO Are there any suits currently pending from previous policies?

YES NO Have any settlements or judgments ever been made by or against you in professional liability cases?

**IF THE ANSWER TO EITHER OF THE ABOVE IS YES,
PLEASE LIST THE FUNCTIONS, WHICH HAVE BEEN
EXCLUDED AND PROVIDE A FULL EXPLANATION
ON A SEPARATE SHEET, INCLUDING THE NAME
OF THE CARRIER, THE DATE AND SPECIFIC
INFORMATION CONCERNING ANY LIMITATION.**

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Allied Health Professional Categories

Please check the appropriate designation for which you are qualified by certification, licensure, or special education:

Certified Surgical Technologist

Registered Nurse

Surgical Technologist

Licensed Practical Nurse

YES NO Do you wish to request any additional functions not specified in the scope of practice for your professional category listed above?

IF THE ANSWER TO THE ABOVE IS YES, PLEASE SPECIFY THE FUNCTION(S) AND PROVIDE DOCUMENTATION OF TRAINING AND EXPERIENCE, AND GIVE A FULL EXPLANATION OF THE DETAILS ON A SEPARATE SHEET AND ATTACH.

YES NO Have you ever been publicly or privately warned, reprimanded or censured by a licensing body, a public or private certifying agent, a medical staff, a hospital or other health care facility?

YES NO Are there any claims or administrative agency or court cases pending against you?

YES NO Have any adverse administrative agency or court decisions ever been rendered against you, or have you ever been found guilty of violating any criminal law (excluding minor traffic violations)?

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE PROVIDE A FULL EXPLANATION OF THE DETAILS ON A SEPARATE SHEET AND ATTACH.

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Clinical References

Please supply MISA with names and addresses of three references. One must be a physician, one an employer, and a peer of your choice who can attest to your clinical competence.

1. _____
Name Address

City ST ZIP () TELEPHONE

2. _____
Name Address

City ST ZIP () TELEPHONE

3. _____
Name Address

City ST ZIP () TELEPHONE

Please sign the clinical reference form to be mailed to your listed references. One must be from an employer, one from a non-employer physician, and one from another physician or a peer of your choice who can attest to your clinical competence and adherence to accepted ethics based on their personal knowledge of your professional activities.

It is your responsibility to sign the authorization and release section of this reference form. References to whom you are related or professional partners are not acceptable references.

