Bracey's Nursing Solutions
Fax to 888-519-6535

800-688-6149 - email: nurse.pb1963@gmail.com

Please complete and return to address. Forms submitted without fees will not be processed.

Name:_____ [ ] RN [ ] LVN

Address:_____

City:_____ Sate: _____ Zip:_____

Phone with AC ( ) _____ Cell ( ) _____

Email_____

License Number :_____ State:_____

Location:
[ ] Killeen
[ ] Lubbock
[ ] Other _____

Date (s)_____

Required Course (s):

[ ] Nurse Refresher Class Room	$950.00	$_____
[ ] Nurse Refresher Virtual Class Room	$1,1100	$_____
[ ] Skills Assessment Class Room	$495.00	$_____
	Total	$_____

In lieu of refunds fees may be applied to another date and location up to one year. I understand I must complete all components and pay fees in full in order to have Verification of Completion presented to the TBON. No refund for Non-Attendance. I have read and understand the contents of the registration form and have contacted the Program Administration (800-688-6149) for clarification. I have provided information related to my BON requirements and will not hold Bracey's Nursing Solutions or any of its employees for misrepresentation or completion of the course (s), I am accountable for my performance while in clinical any errors of omission or commission will be reported to the proper licensing agency as well as any abuse or neglect to clients.

Signature:_____ Date:_____

Payments may be made at www.braceyshealthcaretraining using your credit card.

Money Orders Are Not Accepted

If you do not want to use our convenient online payment method, Please submit the Credit Card Authorization form shown below along with this Registration form.

Credit Card Authorization

I, _____ give permission to: ***Bracey's Nursing Solutions*** *to charge the following credit card for the payment for my courses.*

[ ] Visa [ ] MasterCard Other: _____

Credit card Number: _____

Expiration: _____ CVC Number: _____
(CVC is the 3 digit number on the back or four digits on the front of AMX)

Card Holders Name: _____

Address: _____

City: _____ State:____ Zip Code:_____

Phone #:_____ Mobile: _____

Drivers License #:_____ State: _____

E-Mail Address:_____

I, _____ Authorized payment of $_____

For Dates: _____ Location: _____

Printed Name: _____

Signature: _____

Date: _____

You may pay by check. Your verification of completions will not be Provided until check clears.
Returned Checks are charged a $50 return check fee, in additional to any and all bank charge fees.
We can no longer accept money orders due to fraudulent money orders being produced.

Mail to: Bracey's Nursing Solutions
1301 Leader Drive
Killeen, Texas 76549

CRIMINAL BACKGROUND CHECK

Please Print all Requested Information.

Name: _____

Other Names Used: _____

Current Address: _____

City/ State/ Zip Code: _____

Social Security Number_____ Date if Birth_____

Driver's License #_____ State of Issue: _____

Nursing License #_____ State:_____

In connection with my training with *Bracey's Nursing Solutions,* I hereby authorize *Bracey's* Nursing Solutions/ training facility , to conduct a security background check on me. I understand that this security check will cover information such as criminal history, education and employment, sanction/ exclusions and professional licensure/ certifications. I understand that this background check may include information from previous employers relating to my work experience. I herby release *Bracey's Nursing Solutions*. Training facilities, and its employees from all liability resulting from the furnishing of this information. I certify that the statements made by me on this form are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.

I understand that any false statements made herein could void my consideration for training.

Signature: _____ Date: _____

DRUG AND/OR ALCOHOL TESTING CONSENT FOR Testing

I ,_____hereby agree, upon a request made under the drug/alcohol testing policy of *Bracey's Nursing Solutions* and any training facility to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under *Bracey's Nursing Solutions* or any training facility policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination from training. I further authorize and give full permission to have *Bracey's Nursing Solutions* or any training facility's physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to *Bracey's Nursing Solutions* and/or to any governmental / training entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize *Bracey's Nursing Solutions/ training facility* to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I, _____ will hold harmless the *Bracey's Nursing Solutions*,/ training facility its company physician, and any testing laboratory the *Bracey's Nursing Solutions* / training facility might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if *a Bracey's Nursing Solutions* or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless *Bracey's Nursing Solutions*, its company physician, training facilities and any testing laboratory the Company might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT BRACEY'S HEALTHCARE TRAINING WILL REQUIRE A DRUG SCREEN TEST UNDER THIS POLICY WHENEVER I AM INVOLVED IN AN ON-THE-JOB ACCIDENT OR INJURY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL IN THE ACCIDENT OR INJURY EVENT.

_____ _____

Signature Date

_____

Name - Printed