



**MEDICINE HAT
COLLEGE**

Medicine Hat College
299 College Drive SE
Medicine Hat, AB
T1A 3Y6
Telephone: 403.529.3811
Toll Free: 1.866.282.8394
Fax: 403.504.3517

APPLICATION FOR ADMISSION

CONTINUING STUDIES SUPPORTIVE CARE ASSISTANT PROGRAM

APPLICATIONS FOR THIS PROGRAM ARE ONLY ACCEPTED BY EMAIL

Email this completed application form AND documents to registration@mhc.ab.ca

All Applicants for Supportive Care Assistant Program MUST:

- Have completed Grade 10 English with 60% OR ESL(IELTS 6.0; CLB 6; CEFR B2)
- Be at least 18 Years of Age
- Be a Canadian Citizen, permanent resident or been granted refugee status in Canada

Have you previously registered at MHC?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	MHC ID # (if applicable)
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PERSONAL INFORMATION (please type or print clearly AND enter your FULL legal name)

NAME

LEGAL LAST NAME	
LEGAL FIRST NAME	
LEGAL MIDDLE NAME OR INITIAL	Please check if you do not have a middle name. <input type="checkbox"/>
PREFERRED FIRST NAME	
LIST ALL FORMER NAMES (if applicable, e.g., maiden name)	

BIRTHDATE		(YYYY/MM/DD)
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CITIZENSHIP

FIRST LANGUAGE SPOKEN
What is your status, per Citizenship and Immigration Canada rules <input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Student Visa <input type="checkbox"/> Permanent Resident/Landed Immigrant <input type="checkbox"/> Other Visa If not Canadian – Date of entry to Canada (YYYY/MM)
Country of Citizenship

A clear Police Information Check will be required by the placement location. Do you anticipate this being an issue? <input type="checkbox"/> Yes <input type="checkbox"/> No

ALTERNATE CONTACT

LAST NAME	FIRST NAME
HOME TELEPHONE	BUSINESS TELEPHONE
RELATIONSHIP TO APPLICANT	

OTHER

ACCESSIBILITY SERVICES If you have special needs related to a disability, would you like the Accessibility Services Coordinator to contact you? <input type="checkbox"/> YES <input type="checkbox"/> NO
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PERMANENT ADDRESS

STREET, AVENUE, P.O. BOX NUMBER	
CITY OR TOWN	PROVINCE
POSTAL CODE	COUNTRY
E-MAIL ADDRESS	
HOME TELEPHONE	BUSINESS TELEPHONE

MAILING ADDRESS (if different than above)

STREET, AVENUE, P.O. BOX NUMBER	
CITY OR TOWN	PROVINCE
POSTAL CODE	COUNTRY
E-MAIL ADDRESS	
HOME TELEPHONE	BUSINESS TELEPHONE

ACADEMIC INFORMATION

LAST HIGH SCHOOL ATTENDED OR ATTENDING NOW				Alberta Student Number - ASN (if applicable) To find your ASN go to https://learnerregistry.ae.alberta.ca/
NAME	CITY	PROVINCE	COUNTRY	
ARE YOU ATTENDING HIGH SCHOOL NOW?				Will you or do you have a high school diploma?
<input type="checkbox"/> YES If YES, what grade? _____ When will you finish? _____ Y Y Y Y / M M				<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> NO If NO, last grade completed _____ When did you finish? _____				

POST SECONDARY EDUCATION

Attach list if more than two. Attached

Name of University/College/Technical Institute (List MOST RECENT first)	LOCATION City / Province	Last Attended Year / Month	Length of Program	Certificate/Diploma Obtained or Number of Years Completed

REQUIRED ATTACHMENTS

Please include the following as part of your application submission

<input type="checkbox"/> Copy of Government Issued Photo Identification	<input type="checkbox"/> Transcripts	<input type="checkbox"/> Proof of Canadian Citizenship
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DECLARATION OF APPLICANT

The personal information on this form is collected under the authority of the Post-secondary Learning Act of Alberta, the Freedom of Information and Protection of Privacy Act of Alberta (FOIP), the Statistics Act of Canada and the Income Tax Act of Canada. The information will be protected in compliance with FOIP used by the Registrar's Office to determine your eligibility for admission and registration in programs; collecting transcripts; administering records, scholarships and awards; providing student services; and for alumni relations and fundraising. The personal information may be disclosed to academic and administrative units for College planning and research activities; federal and provincial agencies for reporting requirements; contracted or public health care providers, including collaborative educational, funding, and workplace agencies as required; and the Student's Association of Medicine Hat College through data sharing agreements. The information will be retained in accordance with approved Information Management guidelines. If you have any questions about the collection and use of this personal information, please contact the FOIP Coordinator, Medicine Hat College, 299 College Drive SE, Medicine Hat, AB, T1A3Y6, or 403.504.2286 or foip@mhc.ab.ca.

I certify that the information provided is true and complete in all respects and that no information has been withheld. I understand that falsifying or omitting documents or information on this application will result in immediate and permanent dismissal from MHC. Falsified documents may be referred to the appropriate authorities for prosecution of the applicant under the Criminal Code of Canada. The College reserves the right to refuse admission or cancel any admission ruling. I agree, if admitted, to comply with all College policies and understand my rights and responsibilities as a Medicine Hat College student. I agree, if admitted to MHC, to comply with all rules and regulations of the College.

SIGNATURE OF APPLICANT	DATE OF APPLICATION
	DATE