AMERICAN MEDICAL ACADEMY

Park Tower Beach Business Center
5150 E. Pacific Coast Hwy, Suite 200, Long Beach, CA 90804
Toll free 866- 406-9522 Phone 562-936-0062 Fax 866-936-0461
Email info@AmericanMedicalAcademy.org Web Site www.AmericanMedical Academy.org

NCLEX-PN REGISTRATION FORM

Name: _____
Last First Middle Name

Address: _____
Street City State Zip Code

Telephone No: _____ Mobile No.: _____ Work No.: _____

Time to Call: _____ Email: _____

Are You Currently Employed: ☐ YES ☐ NO Employer: _____

EDUCATION BACKGROUND

Please fill out all questions and indicate N/A in areas that are not applicable.

A. NURSING SCHOOL:

Name of School *(List the most recent)*	City / State	Year of Graduation	Diploma / Degree *(CNA , AA, BSN, MA)*

B. GRADUATE SCHOOL:

NAME OF SCHOOL	City / State	Year of Graduation	Diploma / Degree
If Graduate Studies has not been completed, please indicate the number of units earned to date:			

C. NON-NURSING EDUCATION BACKGROUND (IF APPLICABLE):

Name of School *(List the most recent)*	City / State	Year of Graduation	Diploma / Degree *(Major / Minor of Studies)*

EMPLOYMENT HISTORY

Name of Employer	Employment Dates		Summarize the Type of Work Performed and Job Responsibilities
Address	From	To	
Job Title			

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OTHER INFORMATION: (The following information will assist us in determining your exam preparation needs).

Have you previously attended a formal review class? ☐ YES ☐ NO If YES, please answer the following:

Name of Review Center: _____ City / State: _____

List any expectations you may have regarding "live" review class instructions?

_____

_____

List your weakest nursing subject(s) that you would like more instruction focus.

_____

List your strongest nursing subject(s).

_____

Please tell us how you heard of our review programs: ☐ Advertisement ☐ Website ☐ Search Engine _____

☐ Friend _____ ☐ School _____

Note: All information provided herein shall be handled in strict confidence and used solely for American Medical Academy's enrollment purposes and educational review program curriculum

Signature: _____ Date: _____

Please print and mail completed registration
along with your check for the amount of $575 to:

Checks should be made payable to:

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For additional inquiries, please contact us at: ***(866) 406-9522 / (562) 936-0062*** or ***info@AmericanMedicalAcademy.org***
You may also visit our website at: ***www.AmericanMedicalAcademy.org***