

**Chester Career College**  
 751 West Hundred Road, RT 10  
 Chester, VA 23836  
 (804) 751-9191 FAX (804) 751-2599  
**Application for Re-Entry**

OFFICE USE ONLY
Actual Start Date _____
Adm Code _____

I hereby apply for **Re-entry** in accordance with the terms and regulations of RSHT. I acknowledge that I am responsible for a registration re-entry fee of **\$25.00** for all programs. I understand that this fee is non-refundable.

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Street \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State  Zip

Place of Birth \_\_\_\_\_ Date of Birth

Social Security Number  -

Have you ever been convicted of a crime? Yes  No

Have you ever had a Student Loan? Yes  No  If yes, what is the status of the loan? \_\_\_\_\_

**Employment:** Are you currently employed? Yes  No

Company Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Position \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Title \_\_\_\_\_

Does your company offer tuition Yes  No

Which program were you previously enrolled? \_\_\_\_\_

Are you applying for re-entry into this program? Yes  No

If not, which program would you like to enroll?

- |  |                                |                                |  |   |
|--|--------------------------------|--------------------------------|--|---|
| <input type="checkbox"/> Practical Nursing   | <input type="checkbox"/> A. M. | <input type="checkbox"/> P. M. | <input type="checkbox"/> Medical Billing/Coding  | A. M. <input type="checkbox"/> P. M. <input type="checkbox"/> |
| <input type="checkbox"/> Medical Assistant   | <input type="checkbox"/> A. M. | <input type="checkbox"/> P. M. | <input type="checkbox"/> Surgical Technology     | A. M. <input type="checkbox"/> P. M. <input type="checkbox"/> |
| <input type="checkbox"/> Pharmacy Technician | <input type="checkbox"/> A. M. | <input type="checkbox"/> P. M. | <input type="checkbox"/> Radiological Technology | A. M. <input type="checkbox"/> P. M. <input type="checkbox"/> |
| <input type="checkbox"/> Massage Therapy     | <input type="checkbox"/> A. M. | <input type="checkbox"/> P. M. | <input type="checkbox"/> Community Home Health   | A. M. <input type="checkbox"/> P. M. <input type="checkbox"/> |

Why are you applying for re-entry? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

When do you want to re-start? \_\_\_\_\_

If accepted as a student, I agree to comply with all of the rules and regulations of the school, and I know of no conditions that could interfere with the completion of my course. I acknowledge receipt of the catalog.

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date