INTERNATIONAL CAREER INSTITUTE
6425 N. Hamlin Ave. Lincolnwood IL 60712
Tel: 847.929.6129 | Fax: 888.857.4929

STUDENT INQUIRY FORM

STUDENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	
STREET ADDRESS		CITY, ST, ZIP			
EMAIL ADDRESS		PHONE	☐ Mobile ☐ Home ☐ Work		

HOW DID YOU FIRST HEAR ABOUT ICI? Please specify

☐ ICI Alumni, *Name:* _____
☐ Current ICI Student, *Name:* _____
☐ ICI Faculty/Employee, *Name:* _____
☐ Online search, *Where:* _____
☐ Advertisement, *Where:* _____
☐ Other: _____

PROGRAMS OF INTEREST Please check all that apply

Course/s

☐ Basic Nurse Assistant Training Program
☐ Phlebotomy
☐ EKG Technician Training Program
☐ Patient Care Technician Training
☐ Other: _____

Preferred Schedule *Please specify day/time*

☐ Morning: _____
☐ Evening: _____
☐ Weekend: _____
☐ No preference

Funding Source *Circle applicable response*

☐ WIOA, *Approved?* YES NO APPLYING
☐ VA, *Approved?* YES NO APPLYING
☐ SELF-PAY, *Working?* Full Time Part Time
☐ WORK, *Type:* _____

Reason for Pursuing Program

☐ Undecided on goals at present
☐ Career Change/Advancement
☐ Work Requirement
☐ Maintain Certificate/License
☐ Program/School Requirement
☐ Other: _____

Considerations when choosing a school/program

Please rank highest (1) to lowest (10).

___ Passing Rate
___ Class Schedule
___ Job Placement
___ School Facilities
___ School Reputation
___ Payment Plans / Loan
___ Public Transportation
___ Program Cost (Tuition/ Fees)
___ Availability of Financial Aid
___ Other: _____

When are you planning to start the program? _____

Please state other preferences/considerations when deciding to start program at ICI:

_____
_____
_____

STUDENT DEMOGRAPHICS Please check all that apply

GENDER
☐ Male
☐ Female

MILITARY
☐ Vet
☐ Active
☐ N/A

ETHNICITY
☐ White
☐ Hispanic
☐ African American
☐ Asian/Pacific Islander
☐ American Indian/ Alaskan Native
☐ Other: _____

PRIMARY LANGUAGE
☐ English
☐ Other: _____

Other Languages Spoken
_____
_____

IMMIGRATION STATUS
☐ US Citizen
☐ Legal Permanent Resident/Greencard
☐ Student Visa, Exp _____
☐ Working Visa, Exp _____
☐ DACA, Exp _____
☐ Other: _____

DEGREES HELD/EARNED
☐ High School/GED
☐ Certificate
☐ Associates
☐ Bachelors
☐ Post-grad

DISCLAIMER & SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application leads to enrollment in any course, i understand that false or misleading information in my application or interview may result in my release from the program.

SIGNATURE		**DATE**	

FOR ICI USE ONLY:

PROGRAM ADVISEMENT SESSION WITH: DATE: NEXT APPT:	REMARKS:

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STUDENT APPLICATION

STUDENT INFORMATION

LAST NAME			FIRST NAME		MIDDLE NAME		
STREET ADDRESS			CITY, ST, ZIP				
MAILING ADDRESS	Please print if different from above						
EMAIL ADDRESS			PHONE	☐ Mobile ☐ Home ☐ Work			
DATE OF BIRTH		PLACE OF BIRTH		NATIONALITY		SSN	
FATHER'S NAME		OCCUPATION		ADDRESS			
MOTHER'S NAME		OCCUPATION		ADDRESS			

EMERGENCY CONTACT INFORMATION

NAME		RELATIONSHIP		PHONE	
NAME		RELATIONSHIP		PHONE	

EDUCATION HISTORY

SECONDARY EDUCATION

Check one: ☐ Graduated ☐ GED ☐ In-Progress ☐ Did Not Graduate ☐ None Month & Year Graduated: _____

Name of School: _____ City/State/Country (if not US) : _____

List any Honors/Awards/Certificates Received: _____

POSTSECONDARY / COLLEGE, Degree: _____

Check one: ☐ Graduated ☐ In-Progress ☐ Did Not Graduate ☐ None Month & Year Graduated: _____

Name of School: _____ City/State/Country (if not US) : _____

List any Honors/Awards/Certificates Received: _____

POSTSECONDARY / COLLEGE, Degree: _____

Check one: ☐ Graduated ☐ In-Progress ☐ Did Not Graduate ☐ None Month & Year Graduated: _____

Name of School: _____ City/State/Country (if not US) : _____

List any Honors/Awards/Certificates Received: _____

EMPLOYMENT HISTORY Please list current employment first

COMPANY & ADDRESS		JOB TITLE		PERIOD	Fr:	To:
RESPONSIBILITIES						
COMPANY & ADDRESS		JOB TITLE		PERIOD	Fr:	To:
RESPONSIBILITIES						
COMPANY & ADDRESS		JOB TITLE		PERIOD	Fr:	To:
RESPONSIBILITIES						

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STUDENT APPLICATION

MISCELLANEOUS
Have you been Involved in any CRIMINAL OFFENSE, other than minor traffic violations? ☐ YES ☐ NO, If YES please explain below.
Have you, for any reason, been SUSPENDED or DISMISSED from a job? ☐ YES ☐ NO, If YES please explain below.
Have you, for any reason, been SUSPENDED or DISMISSED from school? ☐ YES ☐ NO, If YES please explain below.
In a few words, please state your reason/s for pursuing the programs you are currently enrolling:
In a few words, please state the reason/s why you chose to pursue these programs in ICI:
Please list five (5) goals you want to achieve after graduation from the program at ICI:

DISCLAIMER & SIGNATURE			
I CERTIFY THAT MY ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IF THIS APPLICATION LEADS TO ENROLLMENT IN ANY COURSE, I UNDERTAND THAT FALSE OR MISLEADING INFORMATION IN MY APPLICATION OR INTERVIEW MAY RESULT IN MY RELEASE FROM THE PROGRAM. I ALSO ACKNOWLEDGE THAT THROUGH MY ASSOCIATION WITH INTERNATIONAL CAREER INSTITUTE I WILL MOST LIKELY PARTICIPATE IN EVENTS THAT ARE RECORDED ON BEHALF OF THE INSTITUTE. BY SUBMITTING THIS APPLICATION, I AUTHORIZE INTERNATIONAL CAREER INSTITUTE, ITS ASSIGNS AND THOSE ACTING ON ITS BEHALF FROM ANY LIABILITY ARISING FROM SUCH USE. I WILL ADVISE ICI, IN WRITING, IF FOR ANY EXTRAORDINARY REASON MY PRIVACY MUST BE PROTECTED AFTER THE SUBMISSION OF THIS DOCUMENT.			
SIGNATURE		**DATE**	

FOR ICI USE ONLY:			
COMMENTS:			
PROGRAM ADVISEMENT SESSION WITH		DATE	

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program. or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name_____Full Middle Name_____Last Name _____

Mailing Address _____City: _____State: _____Zip Code _____

Other Names Used_____Telephone_____-_____-_____

States Where You Have Lived? _____

☐ Male ☐ Female Race_____ Height_____Weight_____ Date of Birth_____ Social Security Number_____
(Enter a letter from below)

Hair Color_____ Eye Color_____ Place of Birth_____

Race	**A**	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED *****

Consent To Release Student Information

The Family Educational Rights and Privacy Act of 1974 (FERPA) is a federal law that protects the privacy of student education records, both financial and academic. For the student's protection, FERPA limits release of student record information without the student's explicit written consent. If you wish to authorize International Career Institute to release information to specific individual(s), please complete this form and return it to the school.

Student's Name: _____ Date of Birth: _____
Please print full name (Last, First M.I.)

I hereby authorize the people listed below to have access to and receive any information about my:

- ❑ Financial Aid / Grant / Scholarship Records
- ❑ Billing/Account Details (includes statements, charges, credits, payments, past due amounts, and/or collection activity)
- ❑ Academic / Education Records (includes grades/GPA, registration, academic progress, enrollment info, attendance)
- ❑ Disciplinary/Student Conduct Information
- ❑ Other (please specify): _____

Name/s of individual/s to whom the above listed information may be released:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand the information may be released orally or in the form of copies of written records, as preferred by the requester. I acknowledge by my signature that I am voluntarily giving my consent to International Career Institute to release the information. I understand that this release is in effect until I revoke such consent in writing and the revocation is received in the Student Services Office.

Student's Signature: _____ Date: _____

Release Form for Media Recording

I, the undersigned, do hereby consent and agree that INTERNATIONAL CAREER INSTITUTE, its employees, or agents have the right to take photographs, videotape, or digital recordings of me and to use these in any and all media, now or hereafter known, and exclusively for the purpose of advertisements and media marketing. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to INTERNATIONAL CAREER INSTITUTE, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that INTERNATIONAL CAREER INSTITUTE is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____ Phone: _____

Please print full name (Last, First M.I.)

Address: _____

Street Address Apt No. City State ZIP

Signature: _____ Date: _____

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May be submitted on or before Midterm

PHYSICAL EXAMINATION FORM

STUDENT INFORMATION

LAST NAME				FIRST NAME				MIDDLE NAME	
STREET ADDRESS				CITY, ST, ZIP					
DATE OF BIRTH		PLACE OF BIRTH		GENDER	☐ Male ☐ Female	AGE		DATE 1ST ICI ADMISSION	

RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize International Career Institute to release my Physical Examination Forms to the Program Director and designated school officials, the Illinois Department of Public Health (IDPH) or its designated representatives and other hospitals and clinical affiliates where I might be engaged in clinical instruction as part of my academic training and in the event of a health and safety emergency and/or for compliance audits by IDPH or another state or federal agency fully authorized by law to conduct such audits.

SIGNATURE: _____ **DATE:** _____

PART I. HEALTH HISTORY

(To be filled out by student)

Please check conditions/diseases you have had:

- ☐ Eye Trouble
- ☐ Ear, Nose, Throat Trouble
- ☐ Sinusitis
- ☐ Hearing Difficulty
- ☐ Speech Difficulty
- ☐ Diabetes
- ☐ Insomnia
- ☐ Frequent Anxiety/Depression
- ☐ Recurrent Headaches
- ☐ Recurrent Colds
- ☐ Hay Fever, Asthma
- ☐ Chronic Cough
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Pain/Pressure in Chest
- ☐ Palpitation (Heart)
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Dizziness or Fainting
- ☐ Convulsions or Epilepsy
- ☐ Head Injury
- ☐ Weakness, Paralysis
- ☐ Arthritis, Joint Trouble
- ☐ Back Problems
- ☐ Stomach or Intestinal Trouble
- ☐ Gallbladder Trouble
- ☐ Jaundice or Hepatitis
- ☐ Rupture, Hernia
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Frequent Urination
- ☐ Urinary Tract Infections
- ☐ Painful Urination
- ☐ Mononucleosis
- ☐ Malaria
- ☐ Venereal Disease
- ☐ Tuberculosis / Positive TB Test
- ☐ Scarlet Fever Disease
- ☐ Measles Disease
- ☐ German Measles Disease
- ☐ Mumps Disease
- ☐ Chicken Pox Disease

FEMALES ONLY

- ☐ Irregular Periods
- ☐ Severe Cramps
- ☐ Excessive Flow
- ☐ Abnormal Pregnancy

Has your physical activity been restricted or your education interrupted for medical reasons? ☐ YES ☐ NO, If YES please explain:

Have you been hospitalized or had surgery during the past five years? ☐ YES ☐ NO, If YES please explain:

Do you have a history or are presently dependent on drugs or alcohol? ☐ YES ☐ NO, If YES please explain:

Do you have any allergy/ies? ☐ YES ☐ NO, If YES please explain:

Are you currently taking any medication/s? ☐ YES ☐ NO, If YES please explain:

Do you have any condition which might require adaptation of your training program? ☐ YES ☐ NO, If YES please explain:

Are you currently pregnant? ☐ YES ☐ NO, If YES please indicate due date:

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PHYSICAL EXAMINATION FORM

PART II. PHYSICAL EXAMINATION

(To be filled out by examining health care provider)

To the Examining Health Care Provider: Please review the student's history and complete applicable parts of the examination form in order to help determine if the individual is in sufficiently good health to undertake a program in health occupations.

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Please indicate status of the following systems and describe any abnormalities in the space below :

Eyes, Ears, Nose, Throat	☐ NORMAL ☐ABNORMAL: _____	Genitourinary	☐ NORMAL ☐ABNORMAL: _____
Neck-Thyroid	☐ NORMAL ☐ABNORMAL: _____	Musculoskeletal	☐ NORMAL ☐ABNORMAL: _____
Respiratory	☐ NORMAL ☐ABNORMAL: _____	Metabolic/Endocrine	☐ NORMAL ☐ABNORMAL: _____
Cardiovascular	☐ NORMAL ☐ABNORMAL: _____	Neuropsychiatric	☐ NORMAL ☐ABNORMAL: _____
Gastrointestinal	☐ NORMAL ☐ABNORMAL: _____	Skin	☐ NORMAL ☐ABNORMAL: _____

VISION: Is the student's visual ability sufficient for observation, assessment, and performance of safe patient care?	☐ YES ☐ NO, If NO please explain:
HEARING: Is the student's auditory ability sufficient to hear normal conversation and/or assess health needs?	☐ YES ☐ NO, If NO please explain:
AMBULATION: Is the student able to maintain a center of gravity when met with an opposing force? Can the student tolerate long periods of sitting and/or standing?	☐ YES ☐ NO, If NO please explain:
WEIGHT BEARING/LIFTING: Is the student sufficiently able to bear or lift weights from 25 to 50 pounds to accomplish common health occupation functions?	☐ YES ☐ NO, If NO please explain:
IMMUNE STATUS: Is the student's immune response or status sufficient to allow assignment in all clinical areas and with direct patient contact?	☐ YES ☐ NO, If NO please explain:

PART III. IMMUNIZATION RECORD

(To be filled out by examining health care provider)

REQUIRED TESTS/ IMMUNIZATIONS		LIVE VACCINE RECEIVED (may submit immunization record)			POSITIVE ANTIBODY TITRE (must attach lab report)	FOR PCT STUDENTS ONLY	INFLUENZA VACCINATION (may submit vaccination record)
Measles-Mumps-Rubella (MMR)	Measles (Rubeola)	Dose 1 Date:			Test Date:		*Vaccination must be performed in the US within 12 months of clinical end date*
		Dose 2 Date:					
	Mumps	Dose 1 Date:			Test Date:		
OR	Rubella	Dose 1 Date:			Test Date:		Date Administered: _____
Tetanus-Diphtheria-Pertussis		Dose 1 Date:	☐ Td ☐Tdap ☐DTP	**OR**	Test Date:		Type: ☐ Flu Shot ☐ Nasal Spray
		Dose 2 Date:					Manufacturer of Flu Shot Solution:
		Dose 3 Date:					
Varicella		Dose 1 Date:			Test Date:		
		Dose 2 Date:					Expiration Date: _____
Hepatitis B		Dose 1 Date:			Test Date:		
		Dose 2 Date:					Lot# _____
		Dose 3 Date:					

TUBERCULOSIS Tests must be performed in the US within 12 months of clinical end date	PPD Tuberculin Skin Test	Date Planted: Date Read: Result: ____ mm Induration ☐ POS ☐ NEG	IF POSITIVE PPD: Interferon Gamma Release Assay (IGRA) must be performed (SEE BELOW)
	Interferon Gamma Release Assay (IGRA) ☐ T-Spot ☐ QuantiFERON® Gold	Date Obtained: Result: ☐ POS ☐ NEG	IF POSITIVE RESULT (Active or Latent): Provide documentation of treatment with start and end dates. Student may start clinical class once a NEGATIVE result has been obtained.

EXAMINING PRACTITIONER SIGNATURE: _____ **DATE OF EXAMINATION:** _____

PRINTED NAME & TITLE: _____ **PHONE NO:** (_____) _____

CLINIC ADDRESS: _____