Castle Family Health Centers

3605 Hospital Road • Atwater, CA 95301 • (209) 904-3092

Castle Family Health Center Medical Assistant Program

STUDENT APPLICATION

Our Medical Assisting Program at Castle Family Health center is designed to prepare students for entry-level positions in healthcare. This comprehensive program integrates hands-on training at CFHC clinics with proficiency in medical terminology and insurance verifications. Students will develop essential front office skills including written and oral communication, appointment scheduling, and basic computer applications, alongside clinical training in anatomy, patient assessment, and practical procedures under physician direction. Upon completion, graduates will receive certification of completion and guaranteed externship placement within CFHC health centers, ensuring a solid foundation for a successful career in the medical field.

Fee Disclosure

The program fees for our Medical Assisting Program at Castle Family Health Center are **$2500.00**, due upon application approval and no later than **October 24, 2024**. This fee includes curriculum and textbook materials, 2 sets of pre-selected scrubs, required physicals and immunizations, mentorship, the opportunity to sit for a certification of completion, and guaranteed externship placement. Upon successful completion of the program, including the externship and one year of employment, participants ***may be*** eligible for reimbursement of up to 50% of the program fees.

Are you able to pay the program fees of $2500 upon acceptance? Yes ☐ No ☐

Program Requirements

Have you graduated from high school or obtained a diploma/GED Yes ☐ No ☐

Note: As part of our admission process, please note that a Background Check and Drug Test are required. Additionally, students are expected to maintain a minimum of 85% attendance and a GPA of 3.5.

Personal Information

Full name: _____ (*Last* / *First* / *M.I.*) Date of Birth: _____

Address: _____ (*Street address* / *Apt/Unit #*) Phone: _____

_____ (*City* / *State* / *Zip Code*) Email: _____

Emergency Contact: _____ Phone: _____

Are you a citizen of the United States? Yes ☐ No ☐

If no, are you authorized to work in the U.S.? Yes ☐ No ☐

Do you have means of reliable transportation? Yes ☐ No ☐

Do you have dependable access to a laptop/computer and internet? Yes ☐ No ☐

Education

School Name and Address		Did you graduate? *(Yes/No)*	GPA
Junior High			
High School			
Other			

Employment/Work Experience

Have you ever worked for this company? Yes ☐ No ☐ If yes, when? _____

Are you related to anyone who has worked or is working for this company? Yes ☐ No ☐ If yes, name of employee: _____

Please list all employment, if applicable. You may also list work performed on a voluntary basis.

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job title: _____ From: _____ To: _____

Responsibilities: _____

May we contact your previous supervisor for a reference? Yes ☐ No ☐

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job title: _____ From: _____ To: _____

Responsibilities: _____

May we contact your previous supervisor for a reference? Yes ☐ No ☐

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job title: _____ From: _____ To: _____

Responsibilities _____

May we contact your previous supervisor for a reference? Yes ☐ No ☐

Candidate Qualities and Skills

Are you certified in CPR (Cardiopulmonary Resuscitation) and/or basic life support? Yes ☐ No ☐ If so, please indicate the certification expiration date. _____

Are you comfortable with performing tasks such as taking patient histories, measuring vital signs, assisting with examinations, administering medications (under supervision), etc.? Yes ☐ No ☐

Are you willing and able to comply with the program's requirements, including clinical rotations and/or externships? Yes ☐ No ☐

Please describe your experience working with computers, including Microsoft Office applications, typing, and other basic computer skills. _____

_____

Do you have any specific interests within the field of medical assisting such as Pediatrics, Women's Health, Behavioral Health, etc.? Yes ☐ No ☐ If yes, please specify, _____

What qualities or skills do you possess that make you a good candidate for this program?

_____

_____

_____

Why do you want to become a Medical Assistant?

What do you believe are the biggest healthcare challenges facing underserved communities today?

References

Please provide two references.

Full name:		Relationship:	
Company:		Phone:	
Address:		Email:	

Full name:		Relationship:	
Company:		Phone:	
Address:		Email:	

Disclaimer and signature

PLEASE READ CAREFULLY. APPLICANT'S CERTIFICATION, AGREEMENT AND NOTICE. I hereby certify that the facts set forth in the above Medical Assistant Program Application are true and complete to the best of my knowledge. I understand and agree that any misrepresentation or omission of a fact in my application or other information furnished in the selection process may result in immediate disqualification and dismissal at Castle Family Health Centers sole discretion even if such misrepresentation or omission is discovered during my training. I understand that my application may be considered for employment opportunities with Castle Family Health Centers or any affiliated groups. I understand and agree the acceptance to the program will be conditioned upon verification of my reference history and by my **successfully passing a job-related physical examination and drug screening.** I agree to sign all necessary consents for the release of medical information to Castle Family Health Centers for its use in evaluation of my fitness to participate in the program in which I am enrolling. I understand that my participation in the program, is contingent upon my ability to perform the essential functions of the program, with or without reasonable accommodation, I agree that the results of my medical/health screen may be released to appropriate agencies in the event of a worker's compensation injury and/or dispute on payment of a medical claim. I understand that within my first three days, I must furnish identification and proof of legal status in the US. If I fail to do so or fail to supply satisfactory documentation within that time frame, it will result in my immediate dismissal from the program. I understand and agree that if employed with Castle Family Health Centers there is no definite period and my employment may be terminated at the will of Castle Family Health Centers or myself for any reason at all, or for no reason. I also understand that any handbooks, manuals, policies and procedures maintained by Castle Family Health Centers are not contractual in nature and may be modified, added to or subtracted from, as circumstances warrant, in the sole discretion of Castle Family Health Centers.

This application when completed and signed becomes property of Castle Family Health Centers. YOU ARE HEREBY AUTHORIZED TO INVESTIGATE ANY INFORMATION PROVIDED IN THIS APPLICATION FOR ENROLLMENT, EMPLOYMENT, TO EMPLOY ANY AGENT OF YOUR CHOICE TO UNDERTAKE ANY SUCH INVESTIGATIONS AND TO COMMUNICATE WITH ANY PERSON MAKING SUCH AN INVESTIGATION, INCLUDING BUT NOT LIMITED TO, ANY OR ALL OF MY PREVIOUS EMPLOYERS, SCHOOLS, OR OTHER ENTITIES LISTED HEREIN. I AUTHORIZE THE EMPLOYERS, SCHOOLS, AND ALL OTHER PERSON AND ENTITIES NAMED IN THE APPLICATION TO RELEASE ANY INFORMATION TO CASTLE FAMILY HEALTH CENTERS RELEVANT TO THIS APPLICATION FOR ENROLLMENT. I RELEASE CASTLE FAMILY HEALTH CENTERS AND ALL OTHER EMPLOYERS, SCHOOLS, OTHER ENTITIES AND PERSON WITH WHOM CASTLE FAMILY HEALTH CENTERS SO COMMUNICATES OR WHO PROVIDES INFORMATION TO CASTLE FAMILY HEALTH CENTERS FROM ANY LIABILITY WHATSOEVER WHICH MY RESULT FROM SEEKING OR RELEASING SUCH INFORMATION, AND I AGREE TO HOLD THEM HARMLESS FROM LIABILITY WITH RESPECT TO SUCH COMMUNCATION

_____	_____	_____
Your Signature	Print	Date

Please submit completed applications No Later Than 10/1/2024 to: castlemaprogram@cfhcinc.org