



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

## Castle Family Health Center Medical Assistant Program

### STUDENT APPLICATION

Our Medical Assistant 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 at a health center within the community, ensuring a solid foundation for a successful career in the medical field.

### Program Fee Disclosure

There is no charge for the Medical Assistant Program at Castle Family Health Center. The program is fully funded and includes all curriculum and textbook materials, two 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 additional support and benefits.

### 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Street address Apt/Unit #*

\_\_\_\_\_ Email: \_\_\_\_\_  
*City State Zip Code*

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

What time of day would you prefer to attend classes for the Medical Assistant program?

Morning  Afternoon  Evening

## 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?

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

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## 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 COMMUNICATION

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date

Please submit completed applications **No Later Than 1/13/2025** to: [castlemaprogram@cfhcinc.org](mailto:castlemaprogram@cfhcinc.org)

# Important Dates

Thank you for your interest in our Medical Assistant Program; please refer to the following timeline for details of the review process and next steps. If you have any questions, please give us a call at (209) 904-3092. Please note program dates are subject to change.

- **1/13/2025** Application Deadline
- **1/17/2025** Program Acceptance Notification
- **1/20/2025 - 1/22/2025** Accepted students will complete background check and drug screening.
- **1/27/2025** Results from drug/background tests should be confirmed no later than January, 27 2025
- **1/31/2025** Orientation
- **2/3/2025** 1<sup>st</sup> day of instruction