AMERICA HEALTHWAYS EDUCATION

NCLEX RN/LVN REVIEW

Registration and Assessment Form

Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Tel Number: ( ) _____ **Cellphone Number:** ( ) _____

Email Address: _____ **Date of Birth:** _____

Referral Source:

☐ **Nursing Registry** ☐ **Internet (Google, Yelp, etc.)** ☐ **Former Reviewer** ☐ **Relative**

EDUCATIONAL BACKGROUND:

Name of School	Year Graduated	Diploma/Degree

RELATED INFORMATION:

This information will help us determine to your needs toward a thorough educational assessment.

Number of hours available for study: _____

Have you previously attended a formal review class? ☐ **Yes** ☐ **No** **If yes, please provide the detail below:**

_____

Are you a visual person? ☐ **Yes** ☐ **No**

Please tick your preference? ☐ **Live Reviewer** ☐ **Module or video presentation**

What are your expectations on a live supervised instruction class?

_____

What is your weakest nursing subject? _____

List your favorite nursing subject you are most interested with? _____

***** All information provided will be treated as strictly confidential *****

SIGNATURE: _____ **Date Signed:** _____

If you have any queries, please do not hesitate to contact ***Mary De Leon (657) 549-6363 / toll free 1 (855) 203-4362*** *or by email at* ***info@americahealthways.com****.* You can also visit our website at ***www.americahealthways.com***