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 (714) 203-4767*** *or by email at* ***americahealthways@yahoo.com.*** You can also visit our website at ***www.americahealthways.com***