



**NHCO – Affiliate Application**

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Other Number: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

Date of inception of your training school? \_\_\_\_\_

Students training annually at your campuses? \_\_\_\_\_

Current training classes? Circle all that apply below

Phlebotomy I.V. EKG CNA Medical Assisting Other \_\_\_\_\_

Curriculum for each of the modalities in which you teach at your campuses – list all that apply.

\_\_\_\_\_  
\_\_\_\_\_

The NHCO staff will confirm receipt of your paperwork when it is emailed in. They will then reach out to the state to ensure your licensing is in place and current. This will happen within 48 hours of receipt of the application.

**RETURN THIS FORM AND ALL NECESSARY DOCUMENTATION TO: [info@healthcarecertifications.com](mailto:info@healthcarecertifications.com)**

- 1. This form completed in its entirety.**
- 2. Current copy of your state approval to operate your educational services. This document will come from the state.**
- 3. Any other endorsements or accreditations which you currently hold if applicable.**

**IMPORTANT: Affiliate Agreement:** I do hereby acknowledge that all the information submitted in connection with my application to be an affiliate provider with the NHCO is true and correct to the best of my knowledge. I understand that falsified information on this application is grounds for denial of acceptance for affiliation, and may bar me from offering future certifications to my students.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date