APPLICATION FOR INTERNATIONAL STUDENTS

Applicant Information

FULL NAME (Please print clearly)

(Last)	(First)	(Middle Initial)	Date of Birth	DD	MM	YY

HOME COUNTRY ADDRESS

(Street Address)	(Apartment/Unit #)	(City/Province)	State & Country)	(Postal Code)
(☎ Home Phone)	(☎ Business Phone)	(Email Address)	(Passport No.)	

Mailing Address (If Different from Above)

FULL NAME (Please print clearly)

(Last)	(First)	(Middle Initial)

ADDRESS (Please print clearly)

(Street Address)	(Apartment/Unit #)	(City/Province)	(State & Country)	(Postal Code)
(☎ Home Phone)	(☎Alternative Phone)	(Email Address)	(Passport No.)	

Emergency Contact

FULL NAME

(Last)	(First)	(Middle Initial)	Relationship to you:

ADDRESS

(Street Address)	(Apartment/Unit #)	(City/Province)	(State & Country)	(Postal Code)
(☎ Home Phone)	(☎ Alternative Phone)	(Email Address)	(Passport No.)	

Other Information

Is there any information about yourself which you wish us to have in evaluating your qualification for admission (honours, clubs, employment, or other activities?

Will there be anyone accompanying you?	Yes ☐	No ☐
Are you currently living in Canada	Yes ☐	No ☐
If Yes, What kind of visa do you hold?		
Do you have family or friends currently living in Canada	Yes ☐	No ☐

If Yes, Please specify:

Last Name	First Name	Middle Name	Relationship
Address			☎ Phone Number

How did you find out bout MTG Healthcare Academy?	Please check appropriate box(s) below:				
	Website ☐	Internet ☐	Newspaper / Magazine ☐	Friend ☐	Other ☐
	If "other, please specify				

Program Selection	Choose any of the 3 programs you would like to apply for, list down below in order of interest.		
	MTG Healthcare Academy ☐	MOA (Medical Office Assistant) ☐	English Advance Program ☐
	❶ Program Title	Desired Start Date:	
	❷ Program Title	Desired Start Date:	
	❸ Program Title	Desired Start Date:	
	Note: All academic records MUST be submitted with this application. Authenticated originals or certified true copies are required. If the original documents are issued in a language other than English, a certified translation must also be submitted.		

Required Information	Please ensure that you have enclosed the required fees and requirements:	Payment Information
	• $150.00 (CAD) Application Fee (non-refundable)	Accepted payment can be made by credit card (Visa or Master Card) bank transfer, certified check, bank draft, money order.
	• $500.00 (CAD) Credential Assessment Reservation Fee (non-refundable)	

Credit Card Information	☐ Visa	☐ MasterCard
	Expiration Date:(MM/YY)	CVC:(3 digits @ the back of the card)
	Card Number:	Card Holder's Name

Bank Transfer Information	Beneficiary Bank:	Bank Account Number:
	Bank Number:	Transit Number:
	Bank Address:	Telephone No.:

Disclaimer and Signature

By signing this application form, I understand completely of these requirements set by MTG Healthcare Academy. I further agree that all information are true and legal to the best of my knowledge.

Applicant's Name:	Signature:	Date:

CALGARY MAIN CAMPUS
1324 36 Avenue NE, Calgary AB, T2E 8S1 Canada
☎ 403 264 2009/ 403 992 7611
Fax no. 587 352 2049

RED DEERCAMPUS
4815 48 Street, Red Deer, AB, Canada
T4N 1S6 ☎ 403 264 2049 / 403 986 0684
Fax no. 403 986 4815

EDMONTON CAMPUS
Suite 203, 9915 – 51 Avenue NW, AB, Canada
T6E 0A8, ☎ 780 863 8236

www.into@mtghealthcare.com www.mtghealthcare.com

INTERNATIONAL STUDENTS
DEMONSTRATION OF FINANCIAL CAPABILITY FORM

Before a student permit ca be issued, MTG Healthcare Academy must receive proof that the student can cover all expenses associated with studying in Canada. This include but not limited to, tuition fees, living expenses, books, health, school supplies, insurance, and transportation.

Financial capability may be demonstrated through a student's personal fund and / or a sponsor's fund. Students may show more than one sponsor. All funds combined must be equal to or greater than **$24,000.00 CAD.**

Documents dates

*All financial documents must be dated no older than **FOUR MONTHS** prior to the student's preferred start date. The oldest acceptable dates, by term, are as follows:*

Student's preferred start date:	Financial document dates must be:

This form and the supporting financial documents may be emailed or faxed to MTG Healthcare Academy

Student's personal funds

Please complete this section if you are showing your personal bank statement

Name (as it appears on the bank			
Name of financial institution/bank			
Date issued		Total amount available (CAD)	

Sponsor's Affidavit of Support

Please complete this section only if you are showing a sponsor's fund. If you have more than one sponsor, please submit one form per sponsor. The statement of sponsorship (below), must also be competed for MTG Healthcare to accept these funds as part of the student's financial capability.

Sponsor's Name (as it appears on the financial documents)			
Sponsor's Relationship to student			
Date Issued		Total amount available (CAD)	

Document(s) provided (please check all that apply)		
☐ Bank statement	☐ Letter of employment	☐ Tax returns

To be completed and signed by the sponsor

Print sponsor name — Print student's name

I, ______________________________, am willing to sponsor ______________________________

Relationship

who is my ______________________________ for the duration of his/her studies at MTG Healthcare Academy

NOTIFICATION OF LEAVE OF ABSENCE
INTENT TO WITHDRAW INTERNATIONAL STUDENT

Personal Information	Please complete all sections of this form. Incomplete forms will not be accepted. If completing by hand, please write legibly.					
	MTG Identification Number		Date	MM	DD	YY
	Last Name		First Name		Middle Name	
	Address	Street	City		Province	
	Postal Code		Country			
	Email Address		Phone Number			

LEAVE OF ABSENCE/WITHDRAWAL FORM

Please choose one of the following

	MM	DD	YY
☐ I wish to WITHDRAW PERMANENTLY from MTG Healthcare Academy on			
☐ I wish to take a TEMPORARY LEAVE OF ABSENCE effective	MM	DD	YY
Your last date of attendance will be on	MM	DD	YY

REASONS:

Signature	**Date**

INTERNATIONAL STUDENT RELEASE OF INFORMATION

All official international student records are confidential. Information will not be given to any agency or person, other than the student, unless the student has provided written permission.

Record/Information	
	This form authorizes MTG Healthcare Academy to release the following information to the person or organization indicated in the **Third Party Information Section** below:
	☐ International Admission Letter
	☐ International Acceptance Letter
	☐ Educational records (i.e. Transcript of records, Test marks, etc.
	☐ Visa Documents
	☐ Tuition and Fee information
	☐ Health records
	☐ Others (Please specify)

Third-Party Information				
	Last	**First**	**Middle**	**Relationship**
	Street Address		**City**	
	Province	**Country**	**Postal Code**	
	Home Phone Number	**Cellphone Number**	**Email**	
	Last	**First**	**Middle**	**Relationship**
	Street Address		**City**	
	Province	**Country**	**Postal Code**	
	Home Phone Number	**Cellphone Number**	**Email**	

I give my consent/permission for the disclosure of this information voluntarily. I am aware that I may rescind my consent any time by doing so in writing. By signing below, I hereby authorize MTG Healthcare Academy to release information indicated in Record/Information section

Personal Information

Last Name	First Name	Middle Name

Program/Course	**Date of Birth (MM/DD/YY)**
Student Signature	**Witness Signature**

AUTHORIZATION FOR REFUND REQUEST

Note:

Please be advise that student must inform the Office of Registrar via phone call or Email about your intention of Withdrawal. Filling this application is insufficient if student do not inform the Office of Registrar. After submitting this form, the Registrar will review you form and will inform you the amount that you will get refunded.

Reasons for Refund

- ☐ VISA Denial (Please attach confirmation of VISA denial to this form
- ☐ Attending other institution (Please attach a copy of Letter of Acceptance)
- ☐ Medical Reasons (Please attach a copy of Medical Record)
- ☐ Others (Please specify)

Personal Information

Last Name				First Name	Middle Name
Date of Birth	MM	DD	YY	Country of Birth	
Native Language				Social Security Number	
Phone Number				Email Address	

Mailing Address

Street	City	Province
Country	Postal Code	

Method of Payment

☐ VISA	☐ Master Card	☐ American Express
☐ Cash	☐ Cheque	☐ Wire Transfer (Original Transfer Receipt should be attached)
☐ Debit Card	☐ Other (Please specify)	
Note:	Original receipts should be presented or attached. Without the original receipts, the refund request will not be process.	

Date of Payments	MM	DD	YY	Date of Payments made by a third Party	MM	DD	YY
Note:	Please send the registrar the Identification of the 3rd party Payer. If you provide the registrar with the correct information, payments refunds will not be process and could go through someone else's bank account. Please review all the information indicated prior to submission						

Student Signature:	Date:	MM	DD	YY