

# APPLICATION FOR INTERNATIONAL STUDENTS

Applicant Information	<b>FULL NAME</b> (Please print clearly)						
	(Last)	(First)	(Middle Initial)	Date of Birth	DD	MM	YY
	<b>HOME COUNTRY ADDRESS</b>						
	(Street Address)	(Apartment/Unit #)	(City/Province)	State & Country)		(Postal Code)	
	(☎ Home Phone)	(☎ Business Phone)	(Email Address)	(Passport No.)			

Mailing Address (If Different from Above)	<b>FULL NAME</b> (Please print clearly)				
	(Last)	(First)	(Middle Initial)		
	<b>ADDRESS</b> (Please print clearly)				
	(Street Address)	(Apartment/Unit #)	(City/Province)	(State & Country)	(Postal Code)
	(☎ Home Phone)	(☎ Alternative Phone)	(Email Address)	(Passport No.)	

Emergency Contact	<b>FULL NAME</b>				
	(Last)	(First)	(Middle Initial)	Relationship to you:	
	<b>ADDRESS</b>				
	(Street Address)	(Apartment/Unit #)	(City/Province)	(State & Country)	(Postal Code)
	(☎ Home Phone)	(☎ Alternative Phone)	(Email Address)	(Passport No.)	

## Our Locations

### + Calgary Campus

403 264 2009 | 403 992 7611  
Fax: 587 352 2049

1324 36 Avenue NE  
Calgary, Alberta | T2E 8S1

### + Red Deer Campus

403 264 2049 | 403 986 0684  
Fax: 403 986 4815


4811 48 Street  
Red Deer, Alberta | T4N 1S6

### + Edmonton Campus


780 863 8236  
Fax: 780 434 8328


6920 Roper Road NW  
Edmonton, Alberta | T6E 0A8

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 <input type="checkbox"/>	No <input type="checkbox"/>
	Are you currently living in Canada		Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If Yes, What kind of visa do you hold?			
	Do you have family or friends currently living in Canada		Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If Yes, Please specify:			
Last Name		First Name	Middle Name	Relationship
Address			☎ Phone Number	

 mtghealthcare.com

 info@mtghealthcare.com

 MTG Healthcare Academy

 @mtghealthcareacademy

How did you find out about MTG Healthcare Academy?	Please check appropriate box(s) below:				
	Website <input type="checkbox"/>	Internet <input type="checkbox"/>	Newspaper / Magazine <input type="checkbox"/>	Friend <input type="checkbox"/>	Other <input type="checkbox"/>
	If "other, please specify				

Program Selection	Choose <b>which</b> program you would like to apply for:	
	Alberta Health Care Aide <input type="checkbox"/>	Medical Office Assisstant /Unit Clerk /Medical Transcriptionist
	<input type="radio"/> Program Title	Desired Start Date:
<b>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.</b>		

Required Information	Please ensure that you have enclosed the required fees and requirements: <ul style="list-style-type: none"> <li>\$150.00 (CAD) Application Fee (non-refundable)</li> <li>\$500.00 (CAD) Registration Fee/ Reservation Fee (non-refundable but credited to tuition)</li> </ul>	<b>Payment Information</b> Accepted payment can be made by credit card (Visa or Master Card) bank transfer, certified check, bank draft, money order.
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Credit Card Information	<input type="checkbox"/> Visa	<input type="checkbox"/> 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.:

<b>Affirmation</b>		
By signing this application form, I completely understand the requirements set by MTG Healthcare Academy. I further certify that all information are true and correct to the best of my knowledge.		
Applicant's Name:	Signature:	Date:

# INTERNATIONAL STUDENTS DEMONSTRATION OF FINANCIAL CAPABILITY

Before a student permit can be issued, MTG Healthcare Academy must receive proof that the student can cover all expenses associated with studying in Canada. This includes but not limited to, tuition and other school fees, living expenses, expenditure on books, medicines, 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 in the bank's record)			
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 must also be completed 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	

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## NOTIFICATION OF LEAVE OF ABSENCE / INTENT TO WITHDRAW

<b>Personal Information</b>	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				

Please choose one of the following

<input type="checkbox"/> I wish to WITHDRAW PERMANENTLY from MTG Healthcare Academy on	MM	DD	YY
<input type="checkbox"/> 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:**


<b>Signature</b>	<b>Date</b>
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# INTERNATIONAL STUDENT AUTHORIZATION FOR 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.

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

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

I give my voluntary consent/permission for the disclosure of the requested information. I also certify that I may rescind my consent any time in writing. By signing below, I hereby authorize MTG Healthcare Academy to release information indicated in Record/Information section of this form.

<b>Personal Information</b>		
Last Name	First Name	Middle Name
<b>Program/Course</b>		<b>Date of Birth (MM/DD/YY)</b>
<b>Student Signature</b>		<b>Witness Signature</b>

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# AUTHORIZATION FOR REFUND REQUEST

## Note:

Please be advised that student must inform the Office of Registrar through phone call or Email about your intention of Withdrawal and fill up this request form for submission to MTG Healthcare Academy

## Reasons for Refund

VISA Denial (Please attach a copy of the confirmation of VISA denial.)

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	

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## Mailing Address

Street		City	Province
Country		Postal Code	

## Method of Payment

<input type="checkbox"/> VISA	<input type="checkbox"/> Master Card	<input type="checkbox"/> American Express
<input type="checkbox"/> Cash	<input type="checkbox"/> Cheque	<input type="checkbox"/> Wire Transfer (Original Transfer Receipt should be attached)
<input type="checkbox"/> Debit Card	<input type="checkbox"/> 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
<b>Note:</b> Please send the registrar the Identification of the 3 <sup>rd</sup> 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
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