



Date _____

Medical Assisting Program Student Data Form

This information to be kept on file with the Health Sciences Division while you are enrolled in the Medical Assisting (MA) program.

Student Name: _____ Student ID#: _____ Age: _____ Birthdate: _____ I identify my gender as: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> _____	Address: _____ _____ County of Residence: _____ Email: _____ Phone: _____ Alternate #: _____
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Are you a re-admit student from the Shasta College MA program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you attended another MA Program? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what school did you attend and what was the reason for not completing that program? _____ _____
Do you have previous work experience in a healthcare facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, in what position? _____ _____

Are you a veteran? ☐ Yes ☐ No

Are you sponsored by: ☐ Smart Center ☐ CalWORKS ☐ other

Are you receiving Financial Aid for school? ☐ Yes ☐ No
(i.e. California College Promise Grant, Pell Grant, Scholarship, Loan)

Ethnic Background:	
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Black	<input type="checkbox"/> Native American
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other