



HOLI HEALTH

“Registered as a Career College under Ontario Career Colleges Act, 2005”

Pre- Registration Student's Information

Date of Registration/Payment: _____ Student #: _____ BATCH # _____

Last Name: _____ First Name: _____

Middle Name: _____ Mother's Maiden Name: _____

Address #: _____

Apt. & Street # St. Name City Province Postal Code

Mobile Number: _____ Home Phone: _____

Email Address: _____

Date of Birth: _____

Place of Birth: _____

- Class Schedule:
- | | |
|--|--------------|
| <input type="checkbox"/> Weekdays | 8 AM – 2 PM |
| <input type="checkbox"/> Weeknights | 4 PM – 10 PM |
| <input type="checkbox"/> Weekends | 9AM – 5PM |
| <input type="checkbox"/> In-person class | 9AM – 5PM |

How did you hear about our school/ Who referred you?

- Website
 Social media (Fb, Instagram, etc.)
 Work

Person: _____

(Required) Person who referred you if there is.

Authorization: By signing below, I authorize Holi Health School to use my e-signature solely for the purpose of preparing and processing my Student Contract or I will receive the Student Contract and will sign it personally. I agree to return the signed contract to Holi Health School for processing. I understand that it will not be used for any other documents or purposes. **(Please sign inside the box).**

Signature:

(Required)