



# Key Medical Resources K-Pass Registration and Payment Agreement

I'm Interested in:  
 More information on K-Pass!  
 Starting K-Pass Now!

For Office Use:  
Name Badge: \_\_\_\_\_  
Entered into Enrollware: \_\_\_\_\_  
Square Verification \_\_\_\_\_  
License Verification \_\_\_\_\_

## K-Pass Holder Information:

\_\_\_\_\_  
Name (First, Middle, Last)

\_\_\_\_\_  
Address (Street, City, State and Zip)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email

\_\_\_\_\_  
Professional Certificate/License Type (i.e. CNA, RN, Student)      License Number (REQUIRED)

| Sign up for:  | Price    | Auto-Pay<br>(18 month Term) | Quarterly Cash Installments<br>(12 month term) |
|---|----------|-----------------------------|--|
| <input type="checkbox"/> CNA/HHA K-Pass                 | \$270.00 | \$15.00 per month           | \$67.50 per quarter                            |
| <input type="checkbox"/> LVN/Psych Tech K-Pass          | \$360.00 | \$20.00 per month           | \$90.00 per quarter                            |
| <input type="checkbox"/> RN New Grad/Student/RCP K-Pass | \$450.00 | \$25.00 per month           | \$112.50 per quarter                           |
| <input type="checkbox"/> Experienced RN K-Pass          | \$540.00 | \$30.00 per month           | \$135.00 per quarter                           |

## Method of Payment:

- Check (Check Number: \_\_\_\_\_)
- Auto-Pay (18 Month Term) \*Credit Card Required
- Quarterly Cash Installments (12 Month Term) \*First Payment Due Now
- Cash
- Credit Card

## K-Pass Duration:

K-Pass Start Date \_\_\_\_\_  
K-Pass End Date \_\_\_\_\_

Credit/Discount: \_\_\_\_\_

Paid Today: \_\_\_\_\_

Remaining Balance: \_\_\_\_\_

**Auto Pay:** Recurring Payments will be automatically charged to provided Credit Card on the following date(s) each month/week/biweekly: \_\_\_\_\_

**Quarterly Cash Installments:** Cash payments are due the 15th of each quarterly month schedule February 15th , May 15th , August 15th, November 15th. Payments must be made in person to: Key Medical Resources Office at **9744 Crescent Center Drive Suite 506, Rancho Cucamonga Ca, 91730**, during normal Business hours.

\_\_\_\_\_  
Credit Card #

\_\_\_\_\_  
Exp. date

\_\_\_\_\_  
Signature

## K-Pass Payment Agreement:

By signing this document I am agreeing to pay a set amount for the ability to take courses through KEY MEDICAL RESOURCES INC. This set amount covers course fees only and I am responsible for any additional co-payment that relates to the course; materials, books, cards, etc. This will continue through the duration indicated above.

K-Pass holder agrees to pay in full the total price of specified k-pass within the terms indicated above. Failure to pay will result in withholding of course completion certificates, legal actions including collections and further civil action.

K-Pass cannot be refunded, exchanged, or transferred.

Regardless of courses taken within the specified duration the full amount of the K-Pass is to be paid in Full.

\_\_\_\_\_  
Print/Signature

\_\_\_\_\_  
Date