Ultimate Medical Academy
Phone: 888-212-5421
Fax: 800-611-3724
www.ultimatemedical.edu

Information and Authorization Form

Name: _____ SS #:_____ Date of Birth: _____
First Middle Last

Street Address: _____ City: _____State: _____ Zip: _____
(USE PHYSICAL ADDRESS — NO P.O. BOXES)

Primary Phone #: _____ Alternate Phone #: _____

Driver's License Number _____ DL State of Issue: _____

Are you a U.S. Citizen? ☐Yes ☐No Alien Registration #: _____

Personal References – Must provide addresses and phone numbers

1) Name: _____ Phone: _____ Relationship: _____

Street Address: _____ City_____ State: _____ Zip: _____

2) Name: _____ Phone: _____ Relationship: _____

Street Address: _____ City_____ State: _____ Zip: _____

3) Name: _____ Phone: _____ Relationship: _____

Street Address: _____ City_____ State: _____ Zip: _____

Satisfactory Academic Progress Statement

I hereby affirm that I understand my financial aid eligibility is contingent upon maintaining satisfactory academic progress throughout my entire program of study at Ultimate Medical Academy. The Satisfactory Academic Progress Policy, as it is written in the school catalog, has been provided to me.

Acknowledgements

I hereby authorize Ultimate Medical Academy to credit my account with my Title IV financial aid funds for tuition and other educational costs. I understand that once my tuition, fees, books, and materials have been paid, my account may have a credit balance. If I elect Option 1 below, I understand that I may rescind my authorization at any time. In the event that I have satisfied the institutional charges for my program in full, the school will be required to disburse any excess funds to me within 14 days.

Please select OPTION 1, 2 or 3 below by checking the box and signing and dating your selection.

☐**OPTION 1**
I authorize the school to retain the credit balance on my account to cover any additional educational expenses that I may incur prior to the end of my academic program

☐**OPTION 2**
I do not authorize the school to retain a credit balance on my account. I require the school to return funds in excess of current institutional charges immediately to the lender

☐**OPTION 3**
I do not authorize the school to retain a credit balance on my account. I require the school to disburse funds in excess of current institutional charges to me

SIGN HERE:
I hereby attest that all information contained on this form is accurate and complete to the best of my knowledge.

Student Signature: _____ **Date:** _____