ENROLLMENT AGREEMENT
Medical Coding and Billing Training

Business Information

Business Name: _____ Date Business Established: _____

Business Address: _____

Contact Name: _____ Contact Title: _____

Contact Telephone Number: _____ Contact E-mail Address: _____

Employer Identification/ Tax ID Number: _____

Total Number of Employees at Business: _____

Please certify the following:

	Yes	*No*
Trainees are, or will become, permanent full-time employees *after* training	☐	☐
Trainees will be paid their current wage during training	☐	☐
All trainees will receive wage gains within 3 months of completion of training *and* these wage gains are a direct result of training and not standard increases.*	☐	☐
All trainees earn less than $60,838/year, including tips, commissions and bonuses	☐	☐

***** *Failure to do so may result in exclusion from future NYC Business Solutions products or services.*

Trainee Information

Trainee #1

Full Name: _____

Job Title: _____

Current hourly wage of trainee: _____

Trainee #2

Full Name: _____

Job Title: _____

Current hourly wage of trainee: _____

Trainee #3

Full Name: _____

Job Title: _____

Current hourly wage of trainee: _____

Trainee #4

Full Name: _____

Job Title: _____

Current hourly wage of trainee: _____

Trainee #5

Full Name: _____

Job Title: _____

Current hourly wage of trainee: _____

Certification

☐ By checking this box, I certify that all of the above information is correct and accurate and commit to meet all of the program requirements as set forth in the attached *Program Guidelines* [insert link].

Signature

I am legally authorized to agree, on behalf of _____("Business"), to the foregoing set of requirements as a condition for the receipt of training provided through NYC Business Solutions. I understand that my business may be denied participation or may be removed from the program at any point for non-compliance with these guidelines. I understand that noncompliance with these requirements may also result in the exclusion of my business from participation in future NYC Business Solutions products and services. I also agree to indemnify and hold harmless the Fund for Public Health in New York, Inc (FPHNY), Workforce Development Corporation, the New York City Economic Development Corporation, the NYC Department of Small Business Services and the City of New York (individually and collectively, the "Indemnitees") from any and all claims, judgments, or liabilities.

_____

Name (PRINT) Title (PRINT)

_____

Signature Date