MOLLOY UNIVERSITY
Division of Continuing Education and Professional Studies
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1000 Hempstead Avenue, Rockville Centre, NY 11570
www.molloy.edu

CLINICAL DOCUMENTATION PROGRAM

Name:_____

Address: _____

City:_____**State:**_____**Zip**: _____

Home Phone: (___)_____ **Cell Phone :**(___)_____

E-mail:_____

Best time to contact you: _____

PROGRAM REQUIREMENTS

- Applicant must be one of the following to enroll in the program
  RN, MD, CCS
- Knowledge or use of ICD 10

APPLICANT WORK/EDUCATIONAL INFORMATION

Employment:_____

Education /degree: _____

Certifications: _____

Do you have knowledge of ICD 10? Explain:

_____

Do you have any previous experience or opportunities in the field? If so, please describe:

_____

_____

_____

Applicants Signature:_____**Date:**_____

Print name:_____

Please email this application to: **vformoso@molloy.edu**