



WEST HILLS
COMMUNITY COLLEGE DISTRICT



HIGH SCHOOL EQUIVALENCY PROGRAM

HEP STAFF COMPLETES THIS SECTION

NAME (Exactly as on ID)		HEP IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE	ZIP
BIRTH DATE	TELEPHONE NO.	ADVISOR:	

HEP DIRECTOR COMPLETES THIS SECTION

STUDENT'S NAME	DATE OF REFERRAL:	GRANT YEAR:
PURPOSE OF REFFERAL <input type="checkbox"/> DENTAL EXAM <input type="checkbox"/> MEDICAL EXAM <input type="checkbox"/> VISION EXAM <input type="checkbox"/> OTHER _____		
HEP Director: Anita Wright	DATE	SIGNATURE

NOTES:

EXAMINER OFFICE COMPLETES THIS SECTION

The person listed above is a participant of the High School Equivalency Program (HEP) at West Hills College and is eligible for services under the agreed upon MOU between WHCCD and your establishment. Please confirm the identity of the person prior to rendering services.

ID Confirmed YES No Receptionist:

Services Rendered:

Costs Incurred: Date of Exam:

SIGNATURE OF AUTHORIZED MEDICAL EXAMINER X	TITLE
	<input type="checkbox"/> Physician <input type="checkbox"/> Optometrist <input type="checkbox"/> Dentist
NAME (PRINT)	

Itemized Costs/Notes:

After Exam Please Return Form To HEP Coordinator:

Javier Cazares
300 Cherry Lane
Coalinga, CA 93210
559-934-2176