

APPLICANT SUBMISSION FORM

Submission deadline for Generic or Extended Program is May 15th
Submission deadline for LPN to RN Transition Program is March 31st

Please remember to include this form as the cover page of your application for admission.

ITEM	ITEM DESCRIPTION	INCLUDED	PENDING
I.	Application for Admission		
II.	\$50 Non-Refundable Application Fee		
	Payable by <u>personal check</u> , <u>cashier's check</u> , <u>certified check</u> , or <u>money order</u> only, made out to Capital Health SON-RMC .		
III.	Three (3) Professional References (friends and family are not valid references)		
IV.	One (1) Official High School Transcripts		
	Name of High School:		
V.	One (1) Official College Transcripts from each college attended		
	a. Name of College:		
	b. Name of College:		
	c. Name of College:		
VI.	Entrance Exam Results		
	a. Test of essential Academic Skills (TEAS). If taken at a testing site other than Capital Health School of Nursing - RMC Trenton Capital Health School of Nursing ADN, you must request ATI forward an official ATI transcript reflecting your results.		
	b. Test of English as a Foreign Language (TOEFL IBT). Required of any applicant educated outside of the U.S.A. for high school or college.		
VII.	LPNs ONLY: A transcript that reflects an approved 3 credit Pharmacology course with a minimum grade of "C" that is less than 2 years old. REQUIRED PREREQUSITE COURSE		
For items	pending, please provide a brief explanation below:		
Applicant	Full Name: Please print		

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APPLICATION FOR ADMISSION

Submission deadline for Generic or Extended Program is May 15th Submission deadline for LPN to RN Transition Program is March 31st

PLEASE PRINT IN INK OR TYPE

Review the application to ensure that all information is complete and accurate. Submit your completed application with all required documents to the above address. *REMEMBER TO INCLUDE THE \$50.00 NON_REFUNDABLE APPLICATION*FEE CHECK BANK CHECK OR MONEY ORDER PAYABLE TO: CAPITAL HEALTH SON-RMC

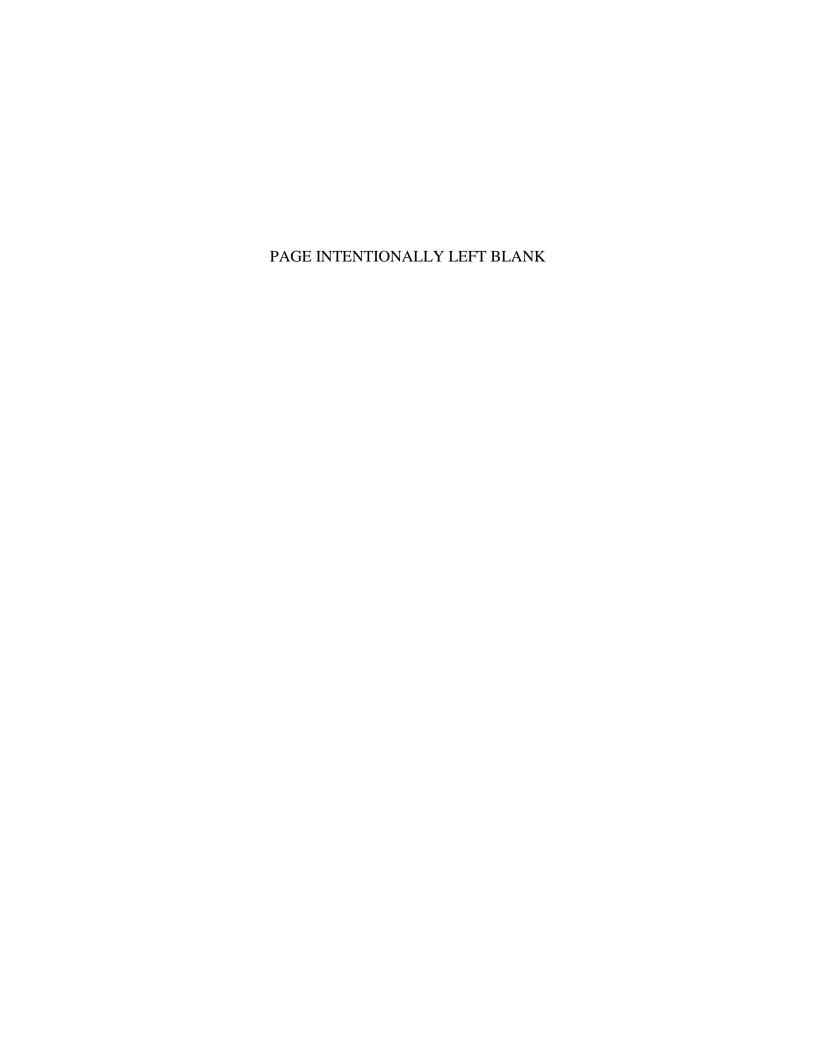
FEE, CHECK, BANK CHECK OR MONEY ORDER, PAYABLE TO: CAPITAL HEALTH SON-RMC									
Today's Date:			Social Securi	ity #:					
Preferred Entrance:	August 20		Preferred	Title	Circle one:	Ms.	Miss	Mrs.	Mr.
Program Option if Interest	Check 🗷 one		C	Other:					
Three (3) Year Program	☐ Extended RN		Last N	ame:					
Two (2) Year Program	☐ Generic RN		First N	ame:					
Nine (9) Month Program	☐ LPN to RN		Middle N	ame:					
Date of Birth:		Previous Last Name(s)							
For Identification Purposes, Year Optional	Month Day Year		(If	any)					
U.S. Citizen:	□ YES □ NO		Preferred "Call" N	ame:					
If NO, provide your visa or		A	ddress: Number and	[
Immigration Status:			Street, Include	Apt #					
Phone – Home:				City:					
Phone – Alt Daytime/Work:			State and ZIP C	Code:					
Phone - Cell:			Cou	unty:					
E-Mail (Indicate proper case):									
Person to be notified in emergency during normal school hours.									
Name: Relationsh			nship:		Telepho	ne:			
GENERAL BACKGROUND: Answer ALL of the following questions.									
Have you previously applied for admission to this school?			□ YES □ NO	If yes,	when?				
Have you ever been convicted of a felony?		□ YES □ NO	If yes,	attach explana	tion.				
Have you ever been a habitual user of drugs?		□ YES □ NO	If yes, attach explanation.						
Are you currently licensed as an LPN?		□ YES □ NO	If yes, win what state?						
Are you or have you ever been a Capital Health employee?		□ YES □ NO	If yes, start date:						
			End da	ate:					
Are you related to a Capital Health employee?		□ YES □ NO	If yes,	name, departn	nent and	relation	ship:		
What do you consider your curre	ent occupation? (Use "s	studer	nt" if appropriate.)						
OPTIONAL INFORMATION: Answers to this section are requested, but not required. Your answers will NOT affect consideration of your application.									
Gender: ☐ Male ☐ Female Marital Status: Ethnic Background: ☐ Hispanic or Latino ☐ Not Hispanic or Latino									
Racial Background: White Black or African American Asjan American Indian or Alaska Native Native Hawaijan or other Pacific Islander									

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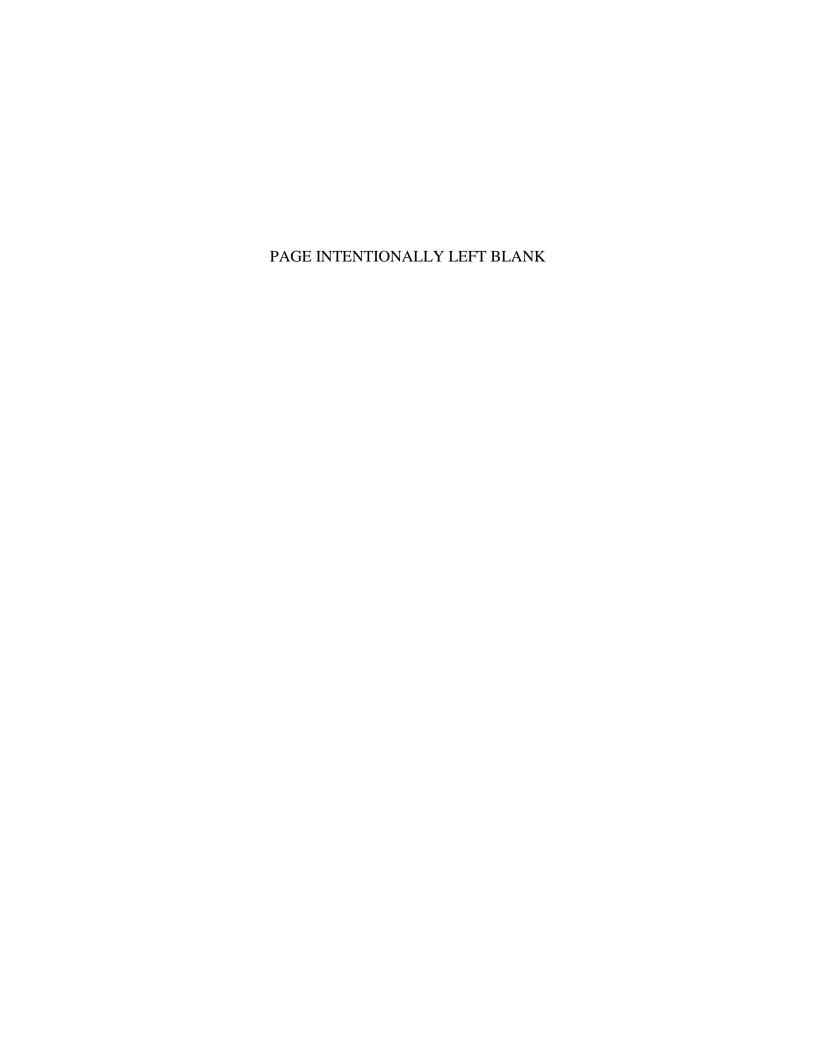
EDUCATIONAL PROFILE

SECONDARY: Li	ist chronologically ALL high schools attended	ded; include GED diploma	, if ap	plicable regardless	s of age or duration.
Dates From – To	es From – To School Name City and State			Diploma Received	
/ to/					
/ to/					
/ to/					
POST-SECONDA	RY: List chronologically ALL formal edu	cation beyond high school	regar	dless of subject, ag	
Dates From – To	School Name	City and State	Ma	jor/Program	Credential Earned or Total Credits
/ to/					
/ to/					
/ to/					
/ to/					
/ to/					
	ERVICE: List chronologically any comm		forme		
Dates From – To	Type of Work	Type of Work Organization		City	and State
/ to/					
/ to/					
/ to/					
/ to/					
/ to/					
@ m m o o o o o o o o o o o o o o o o o					
Dates From – To	List chronologically (most recent first) all Title or Position	1	(both		e) since high school. and State
Dates From - 10	Title of Fosition	Employer		City	and State
/ to/					
/ to/					
/ to/					
/ to/					
/ to/					
/ to/					





APPLICATION ESSAY: In the space below write a concise essay detailing the factors you consider important in your decision to become a Professional Nurse. It will be helpful if you include the following: your activities in recent years; your reasons for selecting a nursing career; any special reasons for your interest in attending this School; the contributions you feel you will make to nursing; and any specific career goals you have at this time. Please try to confine your essay to the space provided.





PROFESSIONAL REFERENCES: Teacher/professor, employer/supervisor, or community service representative.				
Name	Relationship	Occupation		

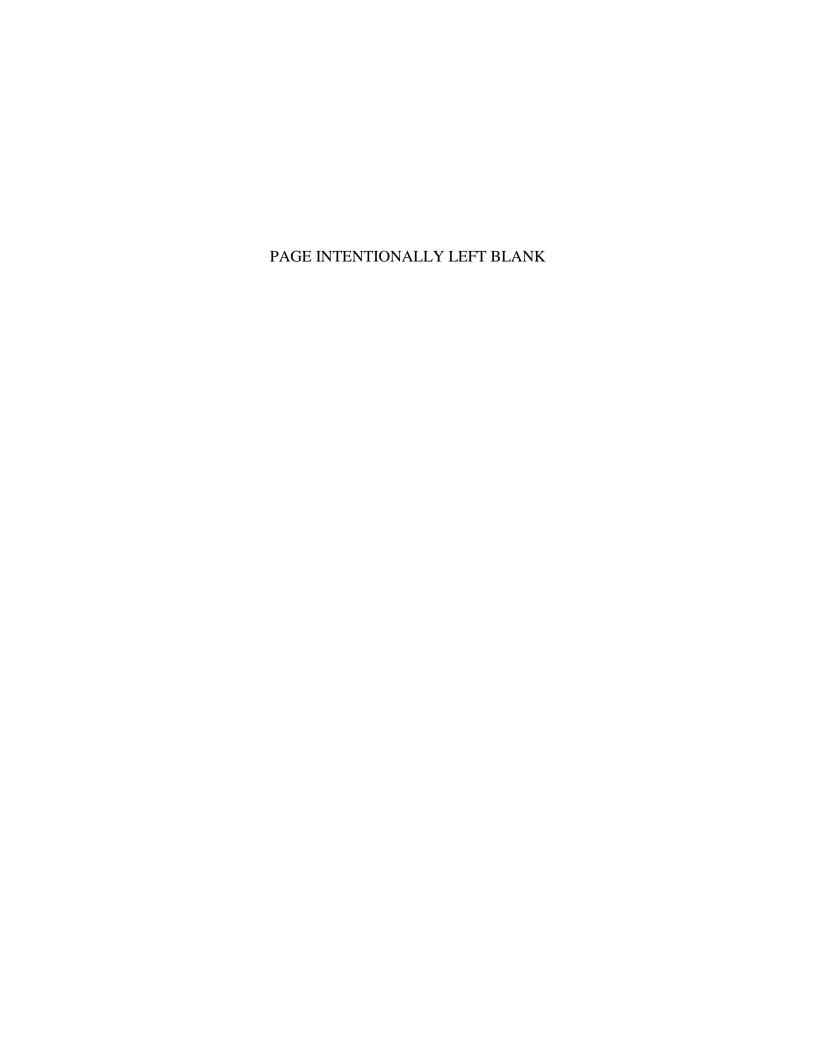
I understand that I may be denied licensure, or permission to sit for a licensing examination, by the State Board of Nursing if I have been convicted of a felony.

By my signature below I certify that all information provided on this application, and any attachments thereto, is true, complete and accurate to the best of my knowledge. I understand that falsification or omission of any requested information is sufficient grounds for rejection of my application or dismissal from the School as a student. I agree that all information provided to the School may be used by the School for any purpose including, but not limited to, making an admissions decision.

I have enclosed my *Non-Refundable* Application Fee of \$50.00.

Applicant's Signature Date

Capital Health School of Nursing – Regional Center admits students of any age, race, color, gender, religion, national or ethnic origin, marital status, sexual orientation, or disability to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of age, race, color, gender, religion, national or ethnic origin, marital status, sexual orientation, or disability in the administration of its educational policies, admissions policies, scholarship or loan programs, or other school administered programs.







ADMISSION REFERENCE

APPLICANT:			
	Print Last Name	Print First Name	Middle Initial
and review this referserving as your professealed envelope. <i>Ma</i> TO THE REFER profession of nursing determine if the approximates this reference of the profession of the approximates and the profession of the approximates are the profession of the approximates are the approximates and the approximates are the approximate	CANT: Complete the information above. Read the inference. After determining your preference regarding the essional reference (i.e., teacher, employer, community til in your sealed reference with application. EENCE: The individual named above has applied to grequires persons of trust, good intelligence and abiliticant will be allowed to inspect and review this reference will not be available for inspection or review by the envelope will expedite the admissions process and we	e Waiver, and signing the statement if you do service representative). Ask him/her to return the School of Nursing and has given your naty, we would appreciate your candid evaluationce, please check the reverse side. If the applicant. Your help in promptly returning	esire, give this form to the person arn the form directly to you in a me as a reference. Since the ion of this applicant. To plicant has signed the Waiver g this form directly to the
1. How long have	you known the applicant?		
2. What has been t	the nature of your acquaintance?		
3. Please commen	t on the applicant's moral character:		
demeanor:	t on the applicant's characteristics in the areas of		
6. Does this applic	cant have any qualities, which might disqualify h	im/her for a nursing career?	
Signature		Address	
Occupation			



TO THE APPLICANT: According to Federal law, if you are admitted to the School of Nursing and eventually enroll, you will have the right to inspect and review the Admissions Reference on the reverse side. You may give up this right by signing the Waiver below. The School is permitted to request, but does not require, that you sign the Waiver. The School does not require the Waiver as a condition for admission to or receipt of a service or benefit from the School. However, we encourage you to sign it to give your reference the confidentiality provided by the Waiver.

WAIVER

If you become an enrolled student in the School of Nursing the *Family Educational Rights and Privacy Act of 1974*, as amended, gives you the right to inspect and review the information on the revere side of this form. The School requests, but does not require, that you waive this right. In considering whether or not to waive your right, please be aware that the information on the reverse side of this form will be used to evaluate you for admission to the School of Nursing. IF YOU CHOOSE TO WAIVE YOUR RIGHT TO INSPECT AND REVIEW THIS ADMISSIONS REFERENCE, PLEASE DATE AND SIGN THIS FORM BELOW.

Date	Signature





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Signature		Printed Name Address	
Occupation –		- 4444 000	
			



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Date	Signature	





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profession of nursing determine if the appl statement this referer	ENCE: The individual named above has applied to to grequires persons of trust, good intelligence and abiliticant will be allowed to inspect and review this reference will <u>not</u> be available for inspection or review by the envelope will expedite the admissions process and wi	y, we would appreciate your candid evaluance, please check the reverse side. If the applicant. Your help in promptly returning	ation of this applicant. To pplicant has signed the Waiver ang this form directly to the
1. How long have	you known the applicant?		
2. What has been to	he nature of your acquaintance?		
3. Please comment	on the applicant's moral character:		
4. Please comment	on the applicant's characteristics in the areas of	work performance, scholastic ability,	integrity and personal
demeanor:			
5. Please list any q	ualities of the applicant which you feel make hir	n/her especially well suited to a career	in nursing:
5. Does this applic	ant have any qualities, which might disqualify hi	m/her for a nursing career?	
Signature		Printed Name	
Date		Address	
Occupation			



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