

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). <i>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.</i> b. Test of English as a Foreign Language (TOEFL IBT). <i>Required of any applicant educated outside of the U.S.A. for high school or college.</i> | | |
| 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 PREREQUISITE 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**

| | |
|---|---|
| Today's Date: _____ | Social Security #: _____ |
| Preferred Entrance: August 20_____ | Preferred Title Circle one: Ms. Miss Mrs. Mr. |
| Program Option if Interest Check <input checked="" type="checkbox"/> one | Other: _____ |
| Three (3) Year Program <input type="checkbox"/> Extended RN | Last Name: _____ |
| Two (2) Year Program <input type="checkbox"/> Generic RN | First Name: _____ |
| Nine (9) Month Program <input type="checkbox"/> LPN to RN | Middle Name: _____ |
| Date of Birth: _____ | Previous Last Name(s) _____ |
| <small>For Identification Purposes, Year Optional</small> Month Day Year | <i>(If any)</i> _____ |
| U.S. Citizen: <input type="checkbox"/> YES <input type="checkbox"/> NO | Preferred "Call" Name: _____ |
| If NO, provide your visa or _____ | Address: Number and _____ |
| Immigration Status: _____ | Street, Include Apt # _____ |
| Phone – Home: _____ | City: _____ |
| Phone – Alt Daytime/Work: _____ | State and ZIP Code: _____ |
| Phone – Cell: _____ | County: _____ |
| E-Mail (Indicate proper case): _____ | |
| Person to be notified in emergency during normal school hours. | |
| Name: _____ Relationship: _____ Telephone: _____ | |
| GENERAL BACKGROUND: Answer ALL of the following questions. | |
| Have you previously applied for admission to this school? | <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, when? _____ |
| Have you ever been convicted of a felony? | <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, attach explanation. |
| Have you ever been a habitual user of drugs? | <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, attach explanation. |
| Are you currently licensed as an LPN? | <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, win what state? _____ |
| Are you or have you ever been a Capital Health employee? | <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, start date: _____ End date: _____ |
| Are you related to a Capital Health employee? | <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, name, department and relationship: _____ |
| What do you consider your current occupation? (Use "student" if appropriate.) _____ | |
| OPTIONAL INFORMATION: Answers to this section are requested, but not required. Your answers will NOT affect consideration of your application. | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: _____ Ethnic Background: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | |
| Racial Background: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander | |

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| ☞ 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.

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ADMISSION REFERENCE

APPLICANT:

| | | |
|-----------------|------------------|----------------|
| | | |
| Print Last Name | Print First Name | Middle Initial |

TO THE APPLICANT: Complete the information above. Read the information on the reverse side regarding the Waiver of your right to inspect and review this reference. After determining your preference regarding the Waiver, and signing the statement if you desire, give this form to the person serving as your professional reference (i.e., teacher, employer, community service representative). Ask him/her to return the form directly to you in a sealed envelope. *Mail in your sealed reference with application.*

TO THE REFERENCE: The individual named above has applied to the School of Nursing and has given your name as a reference. Since the profession of nursing requires persons of trust, good intelligence and ability, we would appreciate your candid evaluation of this applicant. To determine if the applicant will be allowed to inspect and review this reference, please check the reverse side. If the applicant has signed the Waiver statement this reference will not be available for inspection or review by the applicant. Your help in promptly returning this form directly to the applicant in a sealed envelope will expedite the admissions process and will be appreciated. Feel free to use the reverse side for additional comments.

1. How long have you known the applicant? _____
2. What has been the 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 qualities of the applicant which you feel make him/her especially well suited to a career in nursing:

6. Does this applicant have any qualities, which might disqualify him/her for a nursing career?

| | |
|--|--|
| Signature _____ Date _____ Occupation _____ | Printed Name _____ Address _____ _____ |
|--|--|

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 reverse 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 _____



ADMISSION REFERENCE

| | | | |
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Print First Name
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