

APPLICANT SUBMISSION CHECKLIST

Submission deadline for Generic-RN Program is February 28th

Submission deadline for LPN to RN Transition Program is February 28th.

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) must be taken in-person at an ATI Testing Center. You must request ATI forward an official ATI transcript of your results to Capital Health School of Nursing ADN . No more than two attempts at passing the TEAS will be accepted. 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-RN Program is February 28th

Submission deadline for LPN to RN Transition Program is February 28th.

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: _____	
Two (2) Year Program <input type="checkbox"/> Generic RN	Last Name: _____	
One (1) Year Program <input type="checkbox"/> LPN to RN	First Name: _____	
Date of Birth: _____	Middle Name: _____	
For Identification Purposes, Year Optional Month Day Year	Previous Last Name(s) _____	
U.S. Citizen: <input type="checkbox"/> YES <input type="checkbox"/> NO	(If any) _____	
If NO, provide your visa or _____	Preferred "Call" Name: _____	
Immigration Status: _____	Address: Number and _____	
Phone – Home: _____	Street, Include Apt # _____	
Phone – Alt Daytime/Work: _____	City: _____	
Phone – Cell: _____	State and ZIP Code: _____	
E-Mail (Indicate proper case): _____	County: _____	
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 charged or convicted of a crime?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, attach police report and/or court documentation.
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, in 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: _____
If you no longer work for Capital Health, are you eligible for rehire?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, please state reason: _____ _____
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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EDUCATIONAL PROFILE

NURSING PROGRAMS: List chronologically ALL Nursing Programs attended.
Please provide a letter from the Dean of each school stating you were not dismissed for disciplinary reasons.

Dates From – To	School Name	City and State	Diploma Received
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			

SECONDARY: List chronologically ALL high schools attended; include GED diploma, if applicable regardless of age or duration.

Dates From – To	School Name	City and State	Diploma Received
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			

POST-SECONDARY: List chronologically ALL formal education beyond high school regardless of subject, age or duration.

Dates From – To	School Name	City and State	Major/Program	Credential Earned or Total Credits
___ / ___ to ___ / ___				
___ / ___ to ___ / ___				
___ / ___ to ___ / ___				

COMMUNITY SERVICE: List chronologically any community service activities performed.

Dates From – To	Type of Work	Organization	City and State
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			

EMPLOYMENT: List chronologically (most recent first) all work/military experience (both full and part time) since high school.

Dates From – To	Title or Position	Employer	City and State
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			
___ / ___ to ___ / ___			

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

Name	Relationship	Occupation

Have you previously taken the NCLEX-RN exam? YES NO If YES, please list the States, Dates and Results below.

NCLEX - State	Date	Results
		<input type="checkbox"/> PASSED
		<input type="checkbox"/> PASSED
		<input type="checkbox"/> PASSED
		<input type="checkbox"/> PASSED

I understand that I may be denied admission to the school, permission to sit for a licensing examination, or licensure if I have been charged or convicted of a crime.

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.