capitalhealth
SCHOOL OF NURSING
Regional Medical Center

APPLICANT SUBMISSION CHECKLIST

Submission deadline for RN 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 personal check, cashier's check, certified check, or money order 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: ______________________________ d. Name of College: ______________________________		
VI.	**Entrance Test:** a. Entrance test will be comprised of the following topics: Science, Math, English and Reading Comprehension. The Entrance test is to be scheduled with CHSON-RMC. Dates and times to be determined and will be located on the website.		
	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.*		

For items pending, please provide a brief explanation below:

____

____

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Applicant Full Name: ____
Please print

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APPLICATION FOR ADMISSION

Submission deadline for RN 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.
		Other:	______________________
		Last Name:	
		First Name:	
		Middle Name:	
Date of Birth:	____ ____ ____	**Previous Last Name(s)**	______________________
For Identification Purposes, Year Optional	Month Day Year	***(If any)***	
U.S. Citizen:	☐ YES ☐ 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?	☐ YES ☐ NO	If yes, when? ________________________
Have you ever been charged or convicted of a crime?	☐ YES ☐ NO	If yes, attach police report and/or court documentation.
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, in what state? __________________
Are you or have you ever been a Capital Health employee?	☐ YES ☐ NO	If yes, start date:__________________ End date:________________________
If you no longer work for Capital Health, are you eligible for rehire?	☐ YES ☐ NO	If no, please state reason: _______________ ________________________________
Are you related to a Capital Health employee?	☐ YES ☐ 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: ☐ Male ☐ Female **Marital Status**: ____________ **Ethnic Background**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Racial Background: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ 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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☞ **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.**

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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
		☐ PASSED
		☐ PASSED
		☐ PASSED
		☐ 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.