capitalhealth
SCHOOL OF NURSING
601 Hamilton Avenue Trenton, NJ 08629

APPLICANT SUBMISSION FORM

Submission deadline for Generic or Extended Program is March 31st
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 cashier's check, certified check, or money order only, made out to **Capital Health SON**.		
III.	A transcript that reflects a **valid chemistry course**. At least high school level course with a minimum grade of "C' that is less than 10 years old. **REQUIRED FOR APPLICATION**		
IV.	Three (3) Professional References (friends and family are not valid references)		
V.	Two (2) Official High School Transcripts Name of High School: ________________________		
VI.	Three (3) Official College Transcripts from each college attended a. Name of College: ________________________ b. Name of College: ________________________ c. Name of College: ________________________		
VII.	Entrance Exam Results a. Test of essential Academic Skills (TEAS). *If taken at a testing site other than* Capital Health School of Nursing *Trenton (SFMC NJADN), 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.*		
VIII.	**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:

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Applicant Full Name: ____
Please print

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APPLICATION FOR ADMISSION

Submission deadline for Generic or Extended Program is March 31st
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, CASHIER'S CHECK, CERTIFIED CHECK OR MONEY ORDER, PAYABLE TO***: **CAPITAL HEALTH SON**

Today's Date:		**Social Security #:**	
Preferred Entrance:	August 20_____	**Preferred Title**	**Circle one:** Ms. Miss Mrs. Mr.
Program Option if Interest	**Check ☒ one**	Other:	______________________
Three (3) Year Program	☐ Extended RN	**Last Name:**	
Two (2) Year Program	☐ Generic RN	**First Name:**	
Nine (9) Month Program	☐ LPN to RN	**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 completed a Chemistry Course with a minimum "C" grade, that is less than ten (10) years old?	☐ YES ☐ NO	If yes, in ☐ High School ☐ In College
Have you ever been convicted of a felony?	☐ YES ☐ NO	If yes, attach explanation.
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 related to a St. Francis/Capital Health SON alumnus?	☐ YES ☐ NO	If yes, name and relationship: ____________ ______________________________
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

☞ **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 ___ / ___			
___ / ___ 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 ___ / ___				
___ / ___ to ___ / ___				
___ / ___ to ___ / ___				

☞ **COMMUNITY SERVICE: List chronologically any community service activities performed.**

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

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 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 ________________________ **Printed Name** ________________________

Date ________________________ **Address** ________________________

Occupation ________________________ ________________________

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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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