

ST. JOSEPH SCHOOL OF NURSING
 5 WOODWARD AVENUE
 NASHUA, NEW HAMPSHIRE 03060
 (603) 594-2567

Date of Receipt: _____

Application Fee Paid: _____

APPLICATION FOR ADMISSION – Please Check Program of Interest Below

Associate of Science in Nursing Program LPN to RN Transition Course
 Practical Nursing Program Nashua Keene Area
 Health Occupations Program Nursing Assistant Course Day or Evening for Nursing Assistant course only

Please complete all questions on this form and return your completed application in the enclosed envelope with a \$50.00 application fee made payable to St. Joseph Hospital. Applicants may cancel this transaction any time prior to midnight of the third business day following the receipt of this application by the school, after which the application fee becomes non-refundable.

Date: _____ Social Security Number: _____

NAME: _____
 (LAST NAME) (FIRST NAME) (MIDDLE NAME)

SIGNATURE: _____ Home Telephone: _____

HOME ADDRESS: _____

 (City) (State) (Zip Code)

E-MAIL ADDRESS: _____

LPN'S ONLY - State of NH Board of Nursing License #: _____ Expiration date: _____

Country of Birth: _____ U.S. Citizenship: YES NO

Upon acceptance into the School, you will be required to present your original birth certificate, passport, or INS documentation.

Person to be notified in case of an emergency:

NAME: _____ Relationship: _____

ADDRESS: _____ Telephone No: _____

 (City) (State) (Zip Code)

Secondary Education: List all high schools attended.

Date		Name of Institution	City & State	Date of Graduation
From	To			

CED DOCUMENTATION: All applicants attending non-US or non-English speaking high schools should have their transcripts translated by the Center for Educational Documentation. Forms may be acquired at www.cedevaluations.com or by calling (617) 338-7171.

Post-secondary Education: List all formal education beyond high school.

Date		Name of Institution	City & State	Major	Credits or Degree Earned
From	To				

Have you ever taken the TEAS® exam? Yes No

If so, when and where was exam taken? _____

If not, please enter date requested for TEAS® exam (from form included): _____

\$50 Payment for TEAS® exam is included Payment to be made at time of exam

Employment: List your most recent work experiences, both full and part-time, beginning with the present.

Date		Title of Position	Employer	City & State
From	To			

Have you previously applied for admission to this school?

Yes No Which program? _____ Date: _____

Will you be applying for financial aid or a student loan? Yes No

When do you desire to enter? _____

Please list names and addresses of three persons, **not related to you**, who know you and can give information about you. These persons may include a recent instructor, counselor, employer, or clergyman.

1. Name: _____ Position/Title: _____

Address: _____

2. Name: _____ Position/Title: _____

Address: _____

3. Name: _____ Position/Title: _____

Address: _____

Enclosed are three Personal Evaluation forms for you to give to the persons you list above. Applicants for whom these forms are reviewed are free to determine whether or not they wish to waive their potential right to examine the content of the evaluation. We request, **but do not require**, that you read and execute the waiver found on the front of each form.

All of the information on this application is true and complete to the best of my knowledge.

_____ Date

_____ Signature

Please complete the following survey for our information:

How did you hear about St. Joseph School of Nursing?

Newspaper Which one? _____

Internet

Word of mouth

Graduate

Employer

New Hampshire Board of Nursing

School Which one? _____

Other Please specify _____

