Institute for Caregiver Education — Practical Nursing Program
Mailing Address: P.O. Box 548, Scotland, PA 17254
Physical Address: 3583 Scotland Road, Building 55, Scotland, PA 17254

Phone: (717) 263-7766 Fax: (717) 263-7602

APPLICATION FOR ADMISSION

In order to process your application promptly, you are asked to submit the following to the address above:

1. A *non-refundable* check or money order in the amount of $100.00 to cover the cost of the application fee and pre-admission testing (must be enclosed with this application and made payable to Institute for Caregiver Education).
2. A final *official* high school transcript if you have graduated, or upon your graduation (partial transcripts are accepted only if currently attending high school). If applicable, submit GED Score Report.

PERSONAL HISTORY

Name: ____________________ ____________________ ____________________ ____________________
LAST FIRST MIDDLE MAIDEN NAME

PLEASE LIST ANY OTHER NAME(S) YOU MAY HAVE USED IN SCHOOL OR EMPLOYMENT: ________________________________

Address (STREET): ______________________________ (CITY, STATE, ZIP): ______________________________

Home Phone: __________________________ Alternate or Cell Phone: __________________________

Social Security Number: ______________ Date of Birth: ______________ Email Address: ______________

Are you legally able to attend school in the United States? YES____ NO____

Have you been a resident of the State of Pennsylvania continuously for at least the last two (2) years? YES____ NO____

Have you ever pleaded guilty, been convicted of, or pleaded Nolo Contendere (no contest) to any violation other than a summary offense? YES____ NO____

If yes, explain each offense in full:

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Have you ever accepted Accelerated Rehabilitative Disposition (ARD), Probation Without Verdict (PWV) or a similar court monitored program in relation to any violation other than a summary offense? YES____ NO____

If yes, explain each offense in full:

____

____

If yes, to your knowledge was your record expunged? YES____ NO____

Demographic information below is used for statistical purposes only and is not used to determine admission.

Gender: Male____ Female____

Ethnicity: Black (Non-Hispanic)____ Hispanic____ American Indian/Alaskan Native____ Asian or Pacific Islander____
White (Non-Hispanic)____ Non-Resident Alien____ (specify: ____________________)

Place of Birth: ______________________ (If outside USA, date you first entered the United States ____________)

Are you a United States Citizen? YES____ NO____

If NO: You must submit a copy of your I-94 form or Permanent Resident Card (Green Card) prior to enrollment.

What is your country of citizenship? ______________________________

Is English your native (first) language? YES____ NO____

(continued on reverse)

Educational Information

High School (Name/Location): ____

Address (Street): ______________________ (City, State, Zip): ______________________

Area of specialization: ______________ Grade Completed: ________ Approximate Date: __________

Do you have a high school diploma? ______ GED certificate? ______ Date received: ______________

College/Trade/Business School(s):

Name/Location: ____

Area of study: ______________ Diploma/Degree or Years completed: ____________ Date: __________

Name/Location: ____

Area of study: ______________ Diploma/Degree or Years completed: ____________ Date: __________

Have you ever attended another nursing program? YES ____ NO ____ (If yes, provide name, location and dates attended.)

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Employment Information

Current Employer: ______________________________ Phone: ______________

Address: ____

Supervisor's name: ______________________ Employment Dates: __________ To __________

Job Title: ______________ Responsibilities: ______________________________

Previous Employers (please list most recent first):

Position | Company Name/Address | Dates of Employment

______________ ______________________________ __________ To __________

Reason for leaving: ____

______________ ______________________________ __________ To __________

Reason for leaving: ____

EXCERPTS from the Pennsylvania Nurse Practice Act for Practical Nurses (Act 110): "The State Board shall not issue a license or certificate to an applicant who has been convicted of a felonious act prohibited by the Controlled Substance, Drug, Device and Cosmetic Act, or convicted of a felony relating to a controlled substance in court of law of the United States or any other State, Territory, or Country unless: 1. at least ten (10) years have elapsed since the date of conviction; 2. the applicant satisfactorily demonstrates progress in rehabilitation since the conviction and the licensure of the applicant should not be expected to create a substantial risk or harm to the health and safety of patients or the public; 3. the applicant, otherwise satisfies the qualifications contained in, or authorized by, the act. (Convicted shall include a judgment, and admission of guilt or a plea of Nolo Contendere)."

I authorize you to make such investigations and inquiries of my personal, employment, financial or medical history and other related matters as may be necessary in arriving at any enrollment decision. I hereby release employers, schools or persons from all liability in responding to inquiries in connection with my application.

I have read the above information and I certify that the responses I have supplied in this application are true and correct to the best of my knowledge. I hereby understand that any misrepresentation of information I have provided in this application may result in denial of admission or enrollment into the program or dismissal from the program. I also understand that if I am dismissed from the program for providing false information, I am responsible for any balance owed to the school at the time of dismissal. I understand, also, that I am required to abide by all rules and regulations of the Practical Nursing Program.

Applicant's Signature: ______________________________ Date: ______________