



# SEMINOLE STATE COLLEGE

## Nursing Program

### APPLICATION FORM

PO Box 351 Seminole, Oklahoma 74818-0351 (405) 382-9205 (405) 382-9586 fax

LEGAL NAME:

\_\_\_\_\_

First

Middle

Last

ADDRESS:

\_\_\_\_\_

Street

City

State

Zip

CELL PHONE:

\_\_\_\_\_

HOME PHONE:

\_\_\_\_\_

E-Mail:

\_\_\_\_\_

US CITIZEN:

YES

\_\_\_\_\_

NO

\_\_\_\_\_

If No, BCIS ID#:

\_\_\_\_\_

COLLEGE DEGREES HELD:

\_\_\_\_\_

ADMITTED TO SSC:

YES

\_\_\_\_\_

NO

\_\_\_\_\_

ATTENDED CLASSES AT SSC:

YES

\_\_\_\_\_

NO

\_\_\_\_\_

SSC STUDENT ID #

\_\_\_\_\_

Is your major area of study currently listed as "**Nursing**"?

Yes

\_\_\_\_\_

No

\_\_\_\_\_

I don't Know

\_\_\_\_\_

Have you ever been enrolled in an R.N. Program?

Yes

\_\_\_\_\_

No

\_\_\_\_\_

If YES, check type of program:

Diploma

\_\_\_\_\_

Bachelors Degree

\_\_\_\_\_

Associates Degree

\_\_\_\_\_

Where:

\_\_\_\_\_

When:

\_\_\_\_\_

Have you ever been enrolled in an LPN Program?

Yes

\_\_\_\_\_

No

\_\_\_\_\_

Where:

\_\_\_\_\_

When:

\_\_\_\_\_

Year Graduated:

\_\_\_\_\_

Licensing State:

\_\_\_\_\_

Number:

\_\_\_\_\_

If already licensed, do you wish to choose the Career-Mobility Pathway?

(LPN to RN option)

YES

\_\_\_\_\_

NO

\_\_\_\_\_

For preference points indicate if you have recent **Health Care Provider** work experience. Documentation must be provided from the company human resource office on letterhead and must provide your dates of service.

LTC/HH

LPN

PARAMEDIC

OTHER

6-12 months

\_\_\_\_\_

12-24 months

\_\_\_\_\_

>24 months

\_\_\_\_\_

ACT within the last five (5) years?

Yes

\_\_\_\_\_

No

\_\_\_\_\_

**If yes, attach a copy of our results.**



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Indicate the grade received for courses completed and check those in which you are currently enrolled:

Principles of Biology OR General Biology & CHEM	1214	
Human Physiology	2214	
Human Anatomy	2114	
Microbiology*	2224	
General Psychology	1113	

English Comp I	1113	
English Comp II	1213	
U.S. History	1483/93	
U.S. Government	1113	
Pre-Nursing	1104	

**Transcripts must be submitted to validate the above information.**

**The following items are pertinent to your application for taking the RN licensure examination upon graduation, but may not effect consideration for admission to the Nursing Program.**

Have you ever been arrested or convicted of any offense, including a deferred sentence?

YES \_\_\_\_\_ NO \_\_\_\_\_

Have you ever had disciplinary action taken against any health-related license?

YES \_\_\_\_\_ NO \_\_\_\_\_

Have you ever been judicially declared incompetent?

YES \_\_\_\_\_ NO \_\_\_\_\_

If you answered yes, to questions 15, 16 or 17, please see note and instructions below.

**NOTE: The Board of Nursing has the authority to deny a license, recognition or certificate; issue a license, recognition or certificate with conditions and/or an administrative penalty, or to issue and otherwise discipline a license, recognition or certificate to an individual with a history of criminal background, disciplinary action on any professional or occupational license or certification, or judicial declaration of mental incompetence [59 O.S. 567.8]. These cases are considered on an individual basis at the time application for licensure is made, with the exception of felony convictions. Potential applicants to state-approved education programs, with a criminal history, may obtain an initial determination of eligibility for licensure or certification from the Oklahoma Board of Nursing for a fee. The initial determination of eligibility for licensure petition can be accessed at <http://nursing.ok.gov/initialdeterm.pdf>. (Oklahoma Board of Nursing, 59 O.S. 567.12)**

**I verify the above to be correct information. I understand that it is required that I notify the nursing director of any changes or potential changes to my records including, but not limited to the criminal background check, drug screen results, certification/license status or any other legal or medical issues that arise after submission.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I understand that applicants who are admitted to the program will be required to submit a **background check** and a **drug screen** that meet the specific requirements of the healthcare agencies where clinical learning experiences may occur. Based on the results of my background check and/or drug screen, the healthcare agencies may not allow my attendance which will prevent successful completion of the Nursing Program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_