### Step One:
**If you are currently a Chipola College student proceed to step two.**
Submit the following to apply for admission to Chipola College. This step must be completed prior to step two and you must be cleared through the Chipola College Admissions office in order to be considered for the nursing program.

- Application for Admission
- Official High School Transcript/GED
- Official College Transcripts

### Step Two:
Submit/complete the following to apply for the Nursing program. This information should be collected and turned in to the Admissions office at Chipola College.

- Application for Nursing Program
- Official HESI Score (not more than 2 years old)
- Medical History
- Physical Exam
- Immunizations (for descriptions please see the immunization page)
  - Tetanus (Td)
  - Hepatitis B
  - TB/PPD (within last year)
  - Varicella (Chickenpox)/Vaccinex2 or Titer showing immunity
  - MMRx2
- Emergency Medical Release (Notarized)
- Applicant’s Acknowledgement (please read and sign)
- Copy of Health Insurance Card (Required at the time of application)

Letter of Good Standing (if transferring from Nursing Program) (Student’s who have twice earned a grade of D or F in any NUR course are NOT eligible for admission.)

*Once documents are submitted they become Chipola College property and therefore are not accessible after submission. Please make copies of your application and documents prior to submission.*

### Background and Drug Screening Requirements:
- Applicants must complete a background check upon acceptance into the nursing program, background checks will include fingerprinting and drug screen. There is a fee associated with this procedure payment will be expected at the time of service.
- Background checks will be conducted through Chipola College by Mr. Steve Anderson, date, time, and fees will be announced once selections have been made.
- Failure to complete background checks will result in automatic dismissal from the nursing program.
PRE-REQUISITE CHECKLIST

Please retain this copy for your records!

Applicants must meet all eligibility and prerequisite requirements prior to application deadline. If you are currently enrolled in a prerequisite it will impact your total possible points.

Applicants may improve their chances of admission by maintaining a high GPA, completing pre-requisite courses prior to application and scoring high on the HESI nursing entrance exam.

*Please note that completion of ALL these areas will provide a higher score.

Selection is based on a point system

Points will include but are not limited to the following:

*HESI score:

HESI (HEALTH EDUCATION SYSTEMS, INC.)
The HESI test is offered at the Chipola Testing center please call (850) 718-2284 for more information.
Composite Score on Reading and Math subtest must be 75% or higher and not more than 2 years old.

*Pre requisite GPA: PRE-REQUISITES –Must be completed with a grade of “C” or higher and GPA of 2.50
SLS 1101 Orientation
MAC 1105 College Algebra
BSC 2085 A & P I w/lab
ENC 1101 Communication Skills I

*Overall GPA

*Residency in Calhoun, Holmes, Jackson, Liberty or Washington County
*Obtainment of a previous college degree
*Successful completion of BSC 2086 with lab and MCB 2010 with lab

Health Insurance is required by clinical sites. Health Insurance is not provided by Chipola College. Each student must obtain private Health Insurance prior to making application for the nursing program. It is important that each student maintain current health insurance.

The selection process may take up to eight weeks after the application deadline. All students who apply will receive a letter stating their acceptance or denial.
In compliance with Florida Statute 119.071(5), the college collects your Social Security Number for use in the performance of the College’s duties and responsibilities. Federal legislation relating to the Hope Tax Credit requires that all postsecondary institutions report the Social Security Number of all postsecondary students to the Internal Revenue Service. This IRS requirement makes it necessary for colleges to collect the Social Security Number of every student. A student may refuse to disclose his/her Social Security Number to the College, but refusing to comply with the federal requirement may result in fines established by the IRS.

APPLICATION DEADLINE IS SEPTEMBER 24, 2015    SPRING TERM, 2016

Mailing Address ____________________________________________________________

Home Phone ________________________________    Cell Phone ________________________________

Email __________________________________________

Employer Name (if applicable) ________________________________________________

Work Phone ________________________________

Emergency Contact Person _______________________    Relationship ______________________

Day Phone ________________________________    Night Phone ________________________________

Are you currently enrolled in a school/college?   ____ No   ____ Yes

If yes, Where? ___________________________    When will the term end? ___________________________

List courses you are currently enrolled in: _____________________________________________

Have you attended a Nursing program/classes before?   ____No   ____Yes

If yes, where and when ____________________________

If yes, have you attached a letter of good standing   _____No   _____Yes

Students who have twice earned a grade of “D” or “F” in ANY nursing course from ANY institution are ineligible for the nursing program.

Have you previously earned a grade of “D” or “F” in any Nursing Courses at any institution?   ____No   ____Yes

If yes please indicate courses: 
List all schools and colleges attended and degrees/certificates earned.

<table>
<thead>
<tr>
<th>Schools/Colleges (Attach separate sheet if needed.)</th>
<th>Degree and Year Earned</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Answer the next two question. If your answer to any of the following is yes, you must submit a full statement of relevant facts by requesting a Disciplinary Disclosure form from the Admissions Office. Failure to answer the question below will delay processing your application. You may be required to furnish the college with copies of all official documentation explaining the final disposition of the proceedings. If your records have been expunged pursuant to applicable law, you are not required to answer yes to these questions. If you are unsure whether you should answer yes to the question, we strongly suggest that you answer yes and fully disclose all incidents. By doing so, you can avoid any risk of disciplinary action or revocation of an offer of admission.

1. Are you currently or have you ever been, charged with or subject to disciplinary action for scholastic or any other type of misconduct at any educational institution OR medical facility/institution?
   
   ____ NO   ____ YES, Attach separate sheet with explanation.

2. Have you ever been charged with a violation of the law which resulted in, or , if still pending, could result in probation, community service, a jail sentence, the revocation or suspension of your driver’s license (including traffic violations which resulted in a fine of $200 or more)? (If YES, you must submit a full statement of relevant facts by requesting a Disciplinary Disclosure Form from the Admissions Office.)
   
   ____ NO   ____ YES

I certify that I have submitted all of the above information to the Admissions and Records Office.

___________________________________________
Applicant’s Signature

____________________
Date
Chipola College
Health Sciences

APPLICANT’S ACKNOWLEDGEMENT

I understand and agree that I will be bound by the College’s regulations as published in the college catalog and program syllabus/handbook.

I understand that by completing this application, I am not guaranteed admission into the program.

I understand that a FBI Report and Drug Screen are required as part of the application process. I further understand that if the drug test come back positive or if there is a problem with the FBI Report, I may not be accepted or remain in the program.

I understand and agree that I may be randomly drug tested throughout the nursing program. I further understand that if the drug test comes back positive I will be dismissed from the program.

I certify that the information given in this application is complete and accurate and understand that any misrepresentation of facts may result in immediate dismissal from the program.

PLEASE NOTE:

The Nursing Selection Committee will consider all eligible applicants and select the most qualified applicants for admission based on completed courses, current enrollment, and cumulative grade point average in prerequisite courses and overall courses taken. Final acceptance and enrollment is based on the completion with a “C” or better of required courses that are in progress at the time of application, and the completion of other requirements listed below.

If the number of applicants exceeds the available positions, selection will be based on a point system that considers factors such as grades earned in prerequisite courses to the program; overall GPA; credit hours completed at Chipola College; residency in Calhoun, Holmes, Jackson, Liberty or Washington County; and obtainment of a previous college degree. This list is not meant to be all inclusive; Chipola College reserves the right to make changes in the admission criteria as circumstances require. Every reasonable effort will be made to communicate changes in the program to interested students.

Students are strongly encouraged to investigate financial aid eligibility (Pell grants, etc.) at the time of application to the College and/or to the program. Deadline dates for completion of financial Aid are strictly adhered to and those dates can be found on the College Calendar. Students who wait until the time of college registration or until acceptance to the program are generally too late to qualify for funds for that term. Students need to be aware of financial aid limitations regarding minimum credit hours taken per term so that plans can be made to accommodate any adjusted financial resources. Information regarding assistance is available through Financial Aid. In addition to the tuition and fees, there are additional expenses such as textbooks and other course materials and uniforms, which may possibly not be covered by financial aid.

The Florida Board of Nursing has the authority to deny licensure as a registered professional nurse to applicants with a conviction, a plea of no-contest, or guilty plea, regardless of adjudication, for any offense other than a minor traffic violation. Applicants for admission with any record of a criminal charge must report this information to the Vice President of Student Affairs at the time of application. Any charges which arise after admission must also be reported to the Vice President of Student Affairs.

____________________________________________
Applicant’s Signature

__________________________________
Date
MEDICAL HISTORY

INSTRUCTIONS:

APPLICANT - Complete the following then have it reviewed and signed by a practicing, Licensed Physician or ARNP.

PHYSICIAN or ARNP: Please review and sign.

---------------------------------------------

Patient’s Name ________________________________

Indicate current or past problems:

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>CURRENT</th>
<th>PAST</th>
<th>NONE</th>
<th>PROBLEM</th>
<th>CURRENT</th>
<th>PAST</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
<td>Immunosuppression</td>
<td></td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td>Kidney Disease</td>
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<tr>
<td>Arthritis</td>
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<td></td>
<td>Loss of Extremity</td>
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<tr>
<td>Asthma</td>
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<td></td>
<td></td>
<td>Lung Disease</td>
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<tr>
<td>Back problems</td>
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<td></td>
<td></td>
<td>Migraines</td>
<td></td>
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<tr>
<td>Blood Disorder</td>
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<td></td>
<td></td>
<td>Nervousness</td>
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<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td></td>
<td>Pacemaker</td>
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</tr>
<tr>
<td>Cancer</td>
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<td></td>
<td>Peripheral vasc.dis</td>
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<tr>
<td>Chicken Pox</td>
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<td></td>
<td></td>
<td>Prostate Disease</td>
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<tr>
<td>Complicated Pregnancy</td>
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<td></td>
<td></td>
<td>Prosthesis</td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td>Scarlet Fever</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td>Seizures</td>
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<tr>
<td>Dizziness/Fainting</td>
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<td></td>
<td>Shingles/whitlow</td>
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<tr>
<td>Emotional Disorder</td>
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<td></td>
<td></td>
<td>Skin Lesions</td>
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<tr>
<td>Emphysema</td>
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<td></td>
<td></td>
<td>STD</td>
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<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td>Stroke</td>
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<tr>
<td>Frequent Infections</td>
<td></td>
<td></td>
<td></td>
<td>Substance Abuse</td>
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<tr>
<td>Gall Bladder Disease</td>
<td></td>
<td></td>
<td></td>
<td>Surgeries</td>
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<tr>
<td>GERD</td>
<td></td>
<td></td>
<td></td>
<td>Syncope</td>
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<tr>
<td>Glaucoma</td>
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<td></td>
<td></td>
<td>Thyroid Disease</td>
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<tr>
<td>GOUT</td>
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<td></td>
<td></td>
<td>Tobacco Use</td>
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<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
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<tr>
<td>Heart Condition</td>
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<td></td>
<td></td>
<td>Tumors/Growths</td>
<td></td>
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<tr>
<td>Heart Murmur</td>
<td></td>
<td></td>
<td></td>
<td>Ulcer</td>
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<tr>
<td>Heart Palpitations</td>
<td></td>
<td></td>
<td></td>
<td>Valve Prolapsed</td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
<td>Varicose Veins</td>
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<tr>
<td>Hernia</td>
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<td></td>
<td></td>
<td>Vision</td>
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<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>High Blood Pressure</td>
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</table>

I have reviewed the information indicated above.

_____________________________________________  ________________________
Signature of Physician or ARNP                  Date
**PHYSICAL EXAM**

**INSTRUCTIONS:** To be completed by a practicing, licensed physician or ARNP.

Patient’s Name ___________________________  Today’s Date ________________________

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>B/P:</th>
<th>Pulse Rate:</th>
<th>Rhythm:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/Visual</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Ears/Auditory</td>
<td></td>
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<tr>
<td>Nose, Throat, Mouth, Neck</td>
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<tr>
<td>Chest</td>
<td></td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Heart</td>
<td></td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Back/Spine</td>
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<tr>
<td>Extremities</td>
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</tbody>
</table>

Routine Medications:

Drug Allergies:

Food Allergies:

Other Allergies:

Does the patient have an active disease or is any treatment being followed which should be periodically checked? If so, explain:

List Specific Physical Limitations:

Chronic Therapy: (ex: Physical Therapy, Hemodialysis, Chemotherapy)

Note any abnormalities, physical defects, or diseases which might interfere with the student’s attendance and progress in this program.
CURRENT TEST RESULTS:

<table>
<thead>
<tr>
<th>N/A</th>
<th>Date</th>
<th>Within Normal Limits</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Skin Test</td>
<td>___</td>
<td>__________</td>
<td>Within Normal Limits</td>
<td>___</td>
</tr>
<tr>
<td>(or Chest X-ray)</td>
<td>___</td>
<td>__________</td>
<td>Within Normal Limits</td>
<td>___</td>
</tr>
</tbody>
</table>

In my opinion, this applicant is free from communicable disease and will not compromise the immunosuppressed patients with who they will come in contact. The applicant’s physical and mental health is compatible with that required for this program.

The applicant **IS** **IS NOT** able to perform the following occupational activities: walking, standing, and sitting for long periods; stooping, lifting patients, squatting, reaching, twisting, bending, and pushing/pulling/dragging, climbing, and manual dexterity skills.

_______________________________________
Signature of Examining Physician or ARNP

__________ Date

Print Physician’s Name __________________________________________________________

Address __________________________________________________________

Phone __________________________________________________________
REQUIRED IMMUNIZATIONS MUST BE CURRENT:

- TB/PPD or chest x-ray within last year
- Td/Tetanus within last 10 years
- Hepatitis B
- Varicella (Chickenpox) titer or proof of 2 varicella vaccines
- MMRx2

INSTRUCTIONS: Student must provide copy of immunization records or have a physician or ARNP complete the following.

Patient’s Name ___________________________ Date __________________________

Indicate vaccines received, and titers and results, include dates for each or provide copy of immunization record.

**Tuberculosis (required annually)**
Test Results: Date Administered ____________ Date Read: ____________ Results: ____________

Chest X-ray required if TB Test results are positive.  
Date X-rayed: ____________ Chest X-ray results: ____________ (Attach Copy of Report)

**Tetanus**
Tetanus/DT Last Date Given ____________ (must be within 10 years)

**Hepatitis B** (recommended, not required-A signed declination form will be required from student’s who are not immune and choose not to receive the vaccination.)
Hep B Surface Ab titer: Titer Date ____________ Titer result ____________ (Titer results must be attached)  
If not immune: Date of 1st injection ____________; Date of 2nd injection ____________; Date of 3rd injection ____________

**Varicella**
Varicella Titer: Date ____________ Titer results ____________ (Titer results must be attached)  
Varicella Immunization: Date of 1st injection ____________; Date of 2nd injection ____________

**MMR (Measles, Mumps, Rubella)** Needs proof of two MMR vaccines or one mumps, two measles and one rubella vaccine.  NOTE: Any person born before 1/1/57 will need proof of Rubella immunization or positive titer.

Date of 1st MMR: ____________ Date of 2nd MMR: ____________
Measles Titer: Date ____________ Titer Result ____________ (Titer results must be attached)  
Mumps Titer: Date ____________ Titer Result ____________ (Titer results must be attached)  
Rubella Titer: Date ____________ Titer Result ____________ (Titer results must be attached)  

To be completed by Health Care Providers Office!

__________________________  __________________________
Signature of Physician or ARNP  Date
Chipola College
Health Sciences

MEDICAL RELEASE

INSTRUCTIONS: To be completed by ALL students. This MUST BE notarized!

I grant permission to the Health Department or the local hospital or medical doctor to render emergency treatment to me that might be deemed necessary.

I understand that I am responsible for any costs incurred and the College is not financially obligated.

____________________________________
Signature of student, parent, or guardian
(In ink in the presence of Notary Public)

Sworn to and subscribed to me this

day of ________, 20____

____________________________________
Signature of Notary Public