

Student No. _____

YOUNGSTOWN CITY SCHOOLS
CHOFFIN SCHOOL OF PRACTICAL NURSING
Application for Admission

A \$55.00 fee (non-refundable), must be submitted with application. Make payment in the form of a money order **(no personal checks accepted)** Payable to: **Choffin School of Practical Nursing**

Choffin School of Practical Nursing provides admission to all qualified applicants regardless of age, religion/creed, ethnic origin, marital status, race, gender/sex, veteran status or disability which does not interfere with attainment of program objectives.

PLEASE PRINT:

Date _____

Name _____
(Last Name) (First Name) (Middle Name) (Other Names on Transcripts)

Address _____
(Number & Street complete address) (City) (State) (Zip)

Social Security Number

Phone: (____) _____
(Area Code) (Number) County _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

(Name) Phone: _____
(Area Code) (Number)

Relationship _____

(Address)

(City) (State) (Zip)

FOR OFFICE USE ONLY

TEST DATE _____ PASSED _____ FAILED _____ P.E. _____
(Subject)

REFERENCES: Personal references

Requested	Date received
1. _____	_____
2. _____	_____
3. _____	_____

TRANSCRIPT: Requested Date received

Official High School	_____	_____
Official G.E.D.	_____	_____
College	_____	_____
Other	_____	_____

Withdrew Application (date) _____

Reason: _____

It is the policy of the Youngstown City Schools to offer educational activities, employment practices, programs, and services without regard to race, color, national origin, sex, religion, handicap, or age.

Encircle only highest numbers of school years completed:

High School
9 10 11 12

Graduate
Yes No

G.E.D.
Score _____

College
1 2 3 4

COMPLETE NAME OF SCHOOL Last High School Attended	School Address (Number, Street, City, State)	Date (Year) Entered	Date (Year) Graduated	Date (Year) Withdrew
	Street Number			
College or other Education	City, State, Zip Code			
	Street Address			
	City, State, Zip Code			

Grade average in high school? A B C D

School attendance: Good Average Poor If poor, explain _____

List most recent employer first:
State work experience (please include Company Name and Supervisor with proper mailing address)

NAME OF EMPLOYER	ADDRESS (Street, City, State, Zip Code)	Type of Work/Hrs.	Dates	Reason for Leaving

Have you ever applied to or attended:

Attendance Dates

Applied Only

1. A school of professional nursing: Yes No _____ to _____

2. A school of practical nursing? Yes No _____ to _____

Name of school _____

Address of school _____
Street City State Zip Code

Reason for leaving: _____

PERSONAL REFERENCES: Give complete names and addresses of three persons: **NOT RELATIVES OR SIGNIFICANT OTHER** Must include employer or former employer (if ever employed) others teacher, co-worker, clergy, family physician, neighbor, landlord.

1. Name _____ Address _____
Number and Street City, State, Zip Code
Occupation _____ Have known for _____ years.

2. Name _____ Address _____
Number and Street City, State, Zip Code
Occupation _____ Have known for _____ years.

3. Name _____ Address _____
Number and Street City, State, Zip Code
Occupation _____ Have known for _____ years.

HOW DID YOU HEAR ABOUT CHOFFIN SCHOOL OF PRACTICAL NURSING? _____

TO ENABLE YOU TO SUCCESSFULLY COMPLETE THE PROGRAM, WHAT CHANGES WILL BE NECESSARY FOR YOU TO MAKE IN YOUR LIFE? _____

I understand the following statements:

Completing an application for admission to Choffin School of Practical Nursing does not obligate me or the school in regard to my admission. My application will be submitted for review to the faculty that comprise the Admissions Committee.

IF YOU ARE ACCEPTED INTO THE PROGRAM YOU WILL BE TAKING CARE OF PATIENTS WITH A VARIETY OF ILLNESSES INCLUDING INFECTIOUS DISEASES.

TO HAVE THE OPPORTUNITY FOR NEEDED CLINICAL EXPERIENCES AND/OR BE HIRED FOR EMPLOYMENT A CRIMINAL RECORDS CHECK WILL BE REQUIRED. DRUG SCREENING MAY ALSO BE REQUIRED. CLINICAL EXPERIENCE AND/OR EMPLOYMENT MAY BE DENIED RELATED TO CRIMINAL RECORDS CHECK, DRUG SCREENING RESULTS, AND ANY VIOLATION OF THE FACILITIES DRESS CODES.

Anyone entering a pre-licensure nursing education program will also be required to have a criminal records check for the Ohio Board of Nursing (OBN) when applying for licensure in the State of Ohio HB327. NO APPLICANT WILL BE MADE ELIGIBLE FOR THE LICENSING EXAMINATION (NCLEX-PN) WITHOUT THE REQUIRED CRIMINAL RECORDS CHECK BEING COMPLETED AND IN THEIR FILE AT THE OBN AND CHOFFIN SCHOOL OF PRACTICAL NURSING.

The Ohio Board of Nursing, under Chapter 119 of the Revised Code, may deny, revoke, suspend or place restrictions on any license of persons convicted of a crime, felony, or misdemeanor. Any false information will void this application. If already accepted into the program, immediate dismissal will result. This application will not be considered unless these statements have been read and signed by the applicant.

Applicant's Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request that you release to Choffin School of Practical Nursing all information both oral or written regarding my records, character, conduct and performance.

I further release you from all liability which may result from furnishing such information.

Applicant's Signature

Date of Signature

Please note: You will not be considered for admission unless this authorization is signed.