College of Nursing & Health Sciences
SOUTHEAST MISSOURI HOSPITAL

APPLICATION CHECKLIST

ASSOCIATE OF APPLIED SCIENCE – REGISTERED NURSING

Please review the lists below to ensure that you have submitted all documents required for this program.
The items in the left columns are items to submit when you submit the actual application.
The items in the right columns are items to have mailed directly to:

Admissions Office
2001 William Street
Cape Girardeau, MO 63703

Basic Nursing

Submit with Application

- ☐ Application
- ☐ $100 Application Fee
- ☐ Copy of valid Photo Identification
- ☐ Medical History Form & Immunization Records*
- ☐ Reference Letter Waivers
- ☐ Background Check Form

Mail Directly to College

- ☐ Two Reference Letters from employers, teachers, etc
- ☐ **Official** High School or GED Transcripts
- ☐ **Official** transcripts from all colleges, universities, and vocational schools attended
- ☐ ACT Requirement, Compass Exam Scores, or Degree Verification *

LPN to RN

Submit with Application

- ☐ Application
- ☐ $100 Application Fee
- ☐ Copy of valid Photo Identification
- ☐ Medical History Form & Immunization Records*
- ☐ Reference Letter Waivers
- ☐ Copy of LPN License
- ☐ Background Check Form

Mail Directly to College

- ☐ Two Reference Letters from employers, teachers, etc
- ☐ **Official** High School or GED Transcripts
- ☐ **Official** transcripts from all colleges, universities, and vocational schools attended (including LPN school)
- ☐ Nursing ACE I PN-RN Foundations of Nursing Test

Paramedic to RN

Submit with Application

- ☐ Application
- ☐ $100 Application Fee
- ☐ Copy of valid Photo Identification
- ☐ Medical History Form & Immunization Records*
- ☐ Reference Letter Waivers
- ☐ Copy of Paramedic License
- ☐ Paramedic Work Experience Verification
- ☐ Background Check Form

Mail Directly to College

- ☐ Two Reference Letters from employers, teachers, etc
- ☐ **Official** High School or GED Transcripts
- ☐ **Official** transcripts from all colleges, universities, and vocational schools attended *(including Paramedic school)*
- ☐ ACT Requirement, Compass Exam Scores, or Degree Verification *

International Students must receive a 550 or greater on the Test of English as a Foreign Language (TOEFL).

***Note:** if you have been out of high school for 5 years or more, you will need to submit COMPASS test scores or must already have a college degree and submit degree verification. If you've been out of school for less than 5 years, you will need to submit ACT or SAT scores. Also, your immunization records and ACT/SAT scores may be included with your High School transcripts. Check with your high school when requesting your official transcript.*

APPLICATION FOR ADMISSION

A nonrefundable fee of $100.00 is required to process this application. If you are applying for more than one program, a separate application and application fee are required. Valid photo identification is required for application. Please Print.

Personal Information

First Name *Middle* *Last* *Maiden/Aliases*

Social Security Number *Date of Birth (mm/dd/yyyy)* ☐ Male ☐ Female

Mailing Address *City* *ST* *Zip* *County*

Permanent Address (if different) *City* *ST* *Zip* *County*

Home Phone *Cell Phone* *Work Phone*

Email Address

United States Citizen ☐ Yes ☐ No

Emergency Contact

First Name *Last Name* *Relationship*

Street Address *City* *ST* *Zip*

Home Phone *Cell Phone* *Work Phone*

Academic Interest

Associate of Applied Science – Registered Nursing

☐ Basic Nursing (May) ☐ Basic Nursing – Evening/Weekend Track (Oct) OR ☐ First Available Seat

☐ LPN-RN – Accelerated (May) ☐ LPN-RN – Evening/Weekend Track (Oct)

☐ Paramedic – RN (Oct)

☐ Associate of Applied Science – Radiologic Technology

☐ Surgical Technology – Certificate Program

☐ Medical Laboratory Science – Certificate Program *(must have Bachelor's Degree with science course requirements)*

☐ January – November ~OR ~ ☐ July – May

☐ ***Yes, I have applied for admission to this college previously.***

☐ ***Yes, I have attended this college previously.*** _____

Program/year

Student Classification

This application is being made as a(an)

☐ New Freshman (never attended college – excluding dual enrollment, Advanced Placement courses, or early college credit courses taken while in high school)

☐ Transfer Student (previously, or currently, attending another college, university, or post-secondary institution)

☐ Former College of Nursing and Health Sciences Student (enrolled in another program or requesting readmission)

☐ College Degree Previously Obtained _____

Date Earned _____ Institution _____ I

Academic History I

Have all transcripts, GED scores, ACT/SAT testing scores sent directly to the Registrar's Office. High School Seniors will need to submit a current transcript then a final transcript upon graduation. All transcripts must be official. ACT/ SAT scores may be included with your official high school transcripts.

High School Graduation Date *High School* *Street* *City* *ST* *Zip*

GED (General Education Diploma) *State* *Test Date*

Academic History II

Have transcripts for colleges, universities, and vocational schools attended sent directly to the Registrar's office. Please list all colleges, universities, and vocational schools attended. Attach additional list if needed.

Name of School *City/ST* *GPA* *Dates Attended*

Name of School *City/ST* *GPA* *Dates Attended*

Name of School *City/ST* *GPA* *Dates Attended*

Civil or Academic Discipline

Have you ever been suspended or dismissed from any school/college? ☐ Yes ☐ No
Have you ever been placed on academic or disciplinary probation? ☐ Yes ☐ No
Have you ever been convicted of a criminal offense? ☐ Yes ☐ No
If you answered "Yes" to any of the above questions, please explain the reason or nature of the offense.

Background Check

A criminal background check will be performed. By signing this application you are authorizing Southeast Missouri Hospital College of Nursing and Health Sciences to complete this admission requirement. Please complete the following information for each state of residence.

Address	*City*	*ST*	*Zip*	*Dates of Residence*
Address	*City*	*ST*	*Zip*	*Dates of Residence*
Address	*City*	*ST*	*Zip*	*Dates of Residence*

Motivation Statement

Please state your personal and professional goals and how you expect your education will help you achieve these goals. Attach an additional page if needed.

Demographic Information

This information is confidential. It is not used in admission decision, and will not be released except as group statistics for federal, state, and other reports. Questions regarding gender, race, and marriage status are important in determining the effectiveness of efforts related to the provision of equal education opportunity. The providing of this information is optional and your answers will not be used in determining admission status.

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
☐ Dependents (total # dependents) ____ ☐ No Dependents

Ethnicity:
☐ White/NonHispanic ☐ Hispanic/Latino ☐ Black/African Am.
☐ Am. Indian/ AK Native ☐ Asian ☐ Pac. Island / Hawaiian
☐ Two or More Races ☐ Unknown ☐ Other _____

Employment Status:
Are you working? ☐ Full time ☐ Part time
Will you continue working after you begin? ☐ Yes ☐ No

Military Status:
Are you Active Military Duty? ☐ Yes ☐ No
Are you a Veteran? ☐ Yes ☐ No

I affirm that all information supplied is complete and accurate. I understand that any misrepresentation or change of facts could be cause for refusal of admission, cancellation of admission, or suspension from the College. I authorize all educational institutions I have attended to release transcripts or other information relevant to the application to Southeast Missouri Hospital College of Nursing and Health Sciences.

Legal Signature *Date*

Southeast Missouri Hospital College of Nursing and Health Sciences is accredited by the Higher Learning Commission and is a member of the North Central Association.

The Higher Learning Commission of the North Central Association of Colleges and Schools
30 North LaSalle Street, Suite 2400 • Chicago, IL 60602-2504 • 1-800-621-7400

College of Nursing & Health Sciences
SOUTHEAST MISSOURI HOSPITAL

Program:

MEDICAL HISTORY FORM

PLEASE PRINT OR TYPE

This information is confidential and will be used as an aid in providing necessary health care while you are a student. Please return this form with your application.

PERSONAL INFORMATION

Name
last *first* *middle* *maiden/alias)*

Social Security Number | **DOB** | **Age** | ☐ Male ☐ Female

Address | **City** | **ST** | **Zip**

Home Phone | **Work Phone** | **Cell Phone**

Email Address

EMERGENCY CONTACT

Name | **Relationship** | **Phone**

Address | **City** | **ST** | **Zip**

FAMILY PHYSICIAN

Name | Phone

Address | City | ST | Zip

INSURANCE

Medical Insurance Company

Policy No. | Group No.

The College strongly urges every student to subscribe to an insurance plan, which provides comprehensive medical, surgical treatment, & accidental care

DESCRIPTIVE HISTORY

Height | Weight | Eye Color | Hair Color

IMMUNIZATION HISTORY

The Missouri Division of Health is requesting that we have a documented record of student's immunizations. Please include a copy of your immunization records: from your baby book, public health record, high school records, or a copy of your doctor's records Measles, Rubella, Mumps – Recommended are two live immunizations after 12 months of age and a month apart. Thos who have attached a physician's documented proof of disease or titer are considered exempt. Needed vaccinations or titers may be obtained from the Public Health Department in your county.

PERSONAL HEALTH HISTORY

Please answer all the questions and comment on all "yes" answers in the space provided below (dates, complications, etc).

Childhood Diseases	Yes	No	Chronic or Continuing Problems	Yes	No		Yes	No
Measles-*Regular, Hard, Red*	☐	☐	Anemia	☐	☐	Hay Fever	☐	☐
Rubella *3 Day*	☐	☐	Anxiety	☐	☐	Headaches *(recurrent)*	☐	☐
Chicken Pox	☐	☐	Arthritis	☐	☐	Heart Disease	☐	☐
Mumps	☐	☐	Asthma	☐	☐	Congenital Heart Problems	☐	☐
			Chronic Back Problem	☐	☐	Hemophilia	☐	☐
Acute Diseases			Cancer	☐	☐	Hepatitis B	☐	☐
Recurrent painful ear	☐	☐	Chronic Cough	☐	☐	High Blood Pressure	☐	☐
Draining ear	☐	☐	Colitis/Colon Problems	☐	☐	Frequent Indigestion	☐	☐
Hepatitis A	☐	☐	Convulsions or Seizures	☐	☐	Kidney/Bladder Problems	☐	☐
Infectious Mononucleosis	☐	☐	Depression	☐	☐	Malaria	☐	☐
Pleurisy	☐	☐	Diabetes	☐	☐	Mental Disorders	☐	☐
Pneumonia	☐	☐	Diminished Hearing	☐	☐	Sinusitis	☐	☐
Poliomyelitis	☐	☐	Dizziness/Fainting	☐	☐	Tuberculosis	☐	☐
Repeated bouts of Strep Throat	☐	☐	Excessive Drinking or Drug Use	☐	☐	Drug Allergies _____	☐	☐
Urinary Tract Infection	☐	☐	Gall Bladder or Liver Disease	☐	☐	Other Allergies _____	☐	☐
Venereal Disease	☐	☐	Gastric or Duodenal Ulcers	☐	☐	Do you receive allergy shots?	☐	☐
Other (list below)	☐	☐	Other (list below)	☐	☐			

Please explain all "yes" answers, any surgeries, and any serious injuries (broken bones, etc):

FEMALES ONLY – MENSTRUAL HISTORY

☐ Regular ☐ Irregular

Flow: ☐ Heavy ☐ Medium ☐ Light

Pain: ☐ None ☐ Mild ☐ Severe

MISCELLANEOUS INFORMATION

Medications

Any other information that could be of assistance

AUTHORIZATION OF TREATMENT

I do hereby consent, authorize, and request health services personnel and any physician or medical representative to who referral is made to conduct treatment which may deem advisable in the event should I require medical care while a student at Southeast Missouri Hospital College of Nursing and Health Sciences

LEGAL SIGNATURE	**DATE**

**Please Note: Two References are required for each applicant. You may use the form provided below or submit a written letter. If a letter is submitted, please attach the provided reference letter waiver.

College of Nursing & Health Sciences
SOUTHEAST MISSOURI HOSPITAL

Reference Letter Waiver

I, _____, am waiving my right to review this reference letter
(applicant name)
at any time.

_____ _____
(applicant signature) (date)

*Attach this to any reference letters submitted if you decide to waive your right to review your reference.

Cut Here

College of Nursing & Health Sciences
SOUTHEAST MISSOURI HOSPITAL

Reference Letter Waiver

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(applicant name)
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(applicant signature) (date)

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College of Nursing & Health Sciences

SOUTHEAST MISSOURI HOSPITAL

2001 William Street
CAPE GIRARDEAU, MO 63703
PHONE: 573-334-6825 • FAX: 573-339-7805

REFERENCE FORM

Two References are required for each applicant. You may use this form or submit a written letter. If a letter is submitted, please attach the reference letter waiver to the letter. Reference form/reference letter should be returned in a sealed envelope to the above address.

To Be Completed By Applicant

_____

NAME OF APPLICANT (PLEASE PRINT)

☐ By checking this box, I am waiving my right to review this reference form at any time.

_____

SIGNATURE OF APPLICANT *DATE*

To Be Completed By Reference

Please comment on your overall impression of this individual as an applicant to a health care program by the following criteria:

1 = inferior 2 = below average 3 = average
4 = above average 5 = outstanding NA = No opportunity to observe

Initiative	1	2	3	4	5	NA
Responsibility	1	2	3	4	5	NA
Problem Solving Ability	1	2	3	4	5	NA
Cooperation with Others	1	2	3	4	5	NA
Work Independently	1	2	3	4	5	NA
Ability to Follow Instructions	1	2	3	4	5	NA
Honesty	1	2	3	4	5	NA
Communication Skills	1	2	3	4	5	NA
Responds to Suggestions/Corrections	1	2	3	4	5	NA
Ability to Work under Stress	1	2	3	4	5	NA

Additional Comments

_____

_____

_____

Printed Name

_____

Employer Position/Title

_____

Signature Date

Revised: 01/2013

College of Nursing & Health Sciences

SOUTHEAST MISSOURI HOSPITAL

2001 William Street
CAPE GIRARDEAU, MO 63703
PHONE: 573-334-6825 • FAX: 573-339-7805

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To Be Completed By Applicant

_____

NAME OF APPLICANT (PLEASE PRINT)

☐ By checking this box, I am waiving my right to review this reference form at any time.

_____

SIGNATURE OF APPLICANT *DATE*

To Be Completed By Reference

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Communication Skills	1	2	3	4	5	NA
Responds to Suggestions/Corrections	1	2	3	4	5	NA
Ability to Work under Stress	1	2	3	4	5	NA

Additional Comments

_____

_____

_____

Printed Name

_____

Employer Position/Title

_____

Signature Date

Revised: 01/2013

HIGH SCHOOL AND/OR COLLEGE TRANSCRIPT REQUEST FORM

Please complete and submit this Form to former High School and/or all Colleges, Universities, and Vocational Schools attended. In order for your application to be considered by the Admission Committee, all official transcripts must be submitted. Copies may be made of this form if needed.

Full Name

My records would be under the name of

SS # - - | Birth Date

Phone Number(s)

Current Address

City | ST | Zip

Years of Attendance | Graduation Year

Enclosed Fee in the Amount of $ for the transcript request.

Have official transcripts sent directly to:

SOUTHEAST MISSOURI HOSPITAL COLLEGE OF NURSING AND HEALTH SCIENCES
ATTN: ADMISSIONS
2001 WILLIAM STREET
CAPE GIRARDEAU, MO 63703

"I hereby authorize the release of my transcript as indicated."

SIGNATURE *DATE*

College of Nursing & Health Sciences

SOUTHEAST MISSOURI HOSPITAL

PARAMEDIC WORK EXPERIENCE VERIFICATION

Only complete this form if applying for the Paramedic to RN Program.
To be completed and signed by a supervisor.

_____ has worked as a Paramedic (EMT-P) at
Student name

_____ from _____ to _____ .
Institution start date end date

with _____ hours (average) worked weekly.

_____ _____
Supervisor Name/Title Supervisor Signature

_____
Address City ST Zip

_____ _____
Phone Numbers Date

..... ***Cut here*** .....

_____ has worked as a Paramedic (EMT-P) at
Student name

_____ from _____ to _____ .
Institution start date end date

with _____ hours (average) worked weekly.

_____ _____
Supervisor Name/Title Supervisor Signature

_____
Address City ST Zip

_____ _____
Phone Numbers Date

Exhibit B

MHA Management Services Corporation - Background Check Request Form

5/24/2011

MHA Management Services Corporation **P.O. Box 6766, Jefferson City, MO 65102** **Phone: 573/893-3700 Fax: 573/893-7669**	**Name: Southeast Missouri Hospital College of Nursing and Health Sciences, 2001 William St., Cape Girardeau, MO 63701** **Phone: 573-334-6825 Fax: 573-339-7805**

First Name	Middle Name	Last Name

Alias/Maiden Name	Check Alias Name?	Will Employee's Salary Exceed $75,000?
	☐ YES - *Additional Charges May Apply* ☐ NO	☐ NO ☐ YES

Social Security Number	Date of Birth	Race	Gender
	- -		☐ M ☐ F

Mailing Address (NO P.O. Boxes)	City	State	Zip

As part of the ☐ employment ☐ volunteer ☐ student ☐ credentialing process, I consent to the release of my criminal background records and motor vehicle driving records or any search listed below by any and all states or agencies holding such records. I also agree to an investigation and the obtaining of a consumer report solely for ☐ employment ☐ volunteer ☐ student ☐ credentialing purposes. By signing this consent, I acknowledge I have received in writing a Disclosure Regarding Procurement of a Consumer Report. I understand that the Company named above may use this consent on multiple occasions to request such consumer reports.
This consent will remain effective until I have affirmatively revoked it.

_____ **DATE:** _____/_____/_____
Signature of Applicant

BACKGROUND SEARCHES

☐ **OIG** *(Medicare/Medicaid Fraud & Abuse)* ☐ **GSA** *(Federal Procurement Fraud)* ☐ ****FCSR** *(Must Fax Necessary Documents)*
☐ **SSN Verification Plus** *(Address & Alias Name are included)* ☐ **Address Verification** ☐ **Alias Name Search**

☐ **Government Watch List**
(includes *DOC Entity List & Denied Persons List, DOT Specially Designated Nationals & Blocked Persons List, DOS Proliferation List & more)*

☐ ***MO DSS (**Child Abuse/Neglect) - *Need Address/No P.O. Boxes* ☐ **TN Abuse Registry**
☐ ****MO Mental Health Employee Disqualification Registry**

Federal Courts through PACER: ☐ **Nationwide or** ☐ **State 1: _____** **Sex Offender:** ☐ **Nationwide or** ☐ **State 1: _____**

☐ **Driving Record Check: State _____ DL# _____** *(You will be notified if release is needed)*

☐ **Professional License Verification: State _____ Type: _____ License Number: _____**

☐ **Education Verification** ***(****You will be notified if release is needed)***
School Name: _____ City/State: _____/_____ Graduation Date: ____/____/_____
Degree Type Earned: _____ (*BSN, B.A., etc.*) Major: _____ Alias While Attending: _____
If additional Verifications are needed, refer to application during data entry or document on another Background Check Request Form.

☐ **Employment Verification**
Company: _____ Address: _____ City/State: _____/____
Phone: _____/_____-_____ Supervisor: _____ Starting Date: ____/____/_____ Ending Date: ____/____/_____
Title: _____ Duties: _____
Starting Wage: $_____ *Yr/Hr* Ending Wage: $_____ *Yr/Hr* Reason for Leaving: _____
If additional Verifications are needed, refer to application during data entry or document on another Background Check Request Form.

LIST CITY/COUNTY CRIMINAL SEARCHES NEEDED

States with county by county access only: CA, MA, WV and WY

County 1:_____State: _____ County 2:_____State: _____ County 3:_____State: _____

☐ **Puerto Rico Repository (*Felony Only Search* & requires Mother's Maiden Name) _____**

STATEWIDE CRIMINAL

A Statewide/State Repository houses records from all jurisdictions throughout the state.

☐ **AL*** ☐ **AK** ☐ **AZ** ☐ **AR*** ☐ **CO** ☐ **CT*** ☐ **DE** ☐ **DC*** ☐ **FL** ☐ **GA*** ☐ **HI** ☐ **ID**** ☐ **IN** ☐ **IA****
☐ **KS** ☐ **KY** ☐ **LA*** ☐ **ME*** ☐ **MD** ☐ **MI** ☐ **MN** ☐ **MS*** ☐ **MT** ☐ **NE** ☐ **NV*** ☐ **NH**** ☐ **NJ**
☐ **NM*** ☐ **NY*** ☐ **NC** ☐ **ND*** ☐ **OH** ☐ **OK** ☐ **OR*** ☐ **PA** ☐ **RI*** ☐ **SC** ☐ **SD** ☐ **TN** ☐ **TX** ☐ **UT***
☐ **VA*** ☐ **VT*** ☐ **WA** ☐ **WI** ***Note: Louisiana, Nevada & Ohio are Felony Only Searches***

☐ **Illinois Health Care Criminal —** Compliance with Illinois Health Care Worker Background Check Act
(IL State Police Full-State Repository Criminal)

☐ **MO Statewide Criminal—** Includes MO sex offender search, no extra charge
(*MO State Hwy. Patrol Full-State Repository Criminal*)

Requested Form(s) & ** Requested Special Form(s) must be faxed to MSC 573/893-7669 or emailed