



**DR. JOYCELYN ELDERS SCHOOL OF ALLIED AND PUBLIC HEALTH APPLICATION
BACHELOR OF SCIENCE IN NURSING (BSN) PROGRAM**

NAME _____ DATE OF BIRTH _____ SEX: Male/Female (Circle one)
ADDRESS _____ CITY/STATE _____ ZIP CODE _____
STUDENT I.D. NUMBER _____ PHONE NUMBER _____

CERTIFICATIONS:

Certified Nursing Assistant# _____
LPN License# _____
RN License# _____

Have you ever had any encumbrances against your certification/license in Arkansas or any other state? Yes _____ or No _____

Have you ever possessed any other certification to practice in Arkansas or other states? Yes _____ or No _____

If yes, have you had any encumbrances against those certifications/licenses? Please explain _____

PERSONS TO NOTIFY IN CASE OF EMERGENCY:

Name	Address	City/State	Phone No.
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Name	Address	City/State	Phone No.
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Do you have hospitalization or health insurance coverage? Yes _____ or No _____

Have you ever been convicted of a misdemeanor, felony, or pleaded Nolo Contendere to any charge in any state or jurisdiction? Yes _____
or No _____ If yes, please explain _____

Do you have college credits or have been enrolled in any Nursing, Allied Health School, College, or University? Yes _____ or
No _____ If yes, please list the date(s), name(s), and address(s) of all schools attended:

PREVIOUS WORK EXPERIENCE (List most recent first)

EMPLOYER	CITY/STATE	JOB TITLE	FROM	TO
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EDUCATION: HIGHEST GRADE COMPLETED _____ DATE OF GRADUATION OR GED _____

Describe any experiences in the Nursing or Allied Health field _____

Plans after graduation (Optional) _____

- ❖ Individuals who have been convicted of certain crimes may be required to appear before the Arkansas State Board of Nursing before being allowed to take the National Council Licensure Exam (NCLEX-RN) for Nursing. A criminal background check will be required by the Arkansas State Board of Nursing prior to licensure. Convictions of certain crimes may make the applicant ineligible to test for licensure despite successful completion of the program.
- ❖ Random drug screens may be utilized for cause at any time during the program at the student's expense.

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misrepresentation, falsifications, omission of information or attempt to deceive Philander Smith University is cause for either denial of selection for entry or dismissal from enrollment. I authorize Philander Smith University to release information provided by me in the application for admission to the program, to approval/accrediting agencies, and clinical affiliates, as required. This authorization includes the release of my transcript.

DATE

SIGNATURE

The BSN program currently has Initial Approval from the Arkansas State Board of Nursing (ASBN), 1123 South University #800, Little Rock, AR 72204 www.arsbn.org

The BSN program is approved by the Higher Learning Commission (HLC), 230 South LaSalle Street, Suite 7-500, Chicago, IL 60604 hlcommission.org

NOTE: Applicants who fail to submit a complete admission packet to the Division of Nursing by the close of business on the deadline date may not be considered for admission.