

DATE OF BIRTH _____
MONTH/DATE/YEAR

PLACE OF BIRTH _____
CITY/STATE/COUNTY

MARITAL STATUS: SINGLE _____ MARRIED _____ SEPARATED _____ DIVORCED _____ WIDOW _____

NUMBER OF CHILDREN _____ AGES _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU KNOW SOMEONE IN THE PROGRAM CURRENTLY OR A PAST GRADUATE? _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

EMPLOYMENT INFORMATION:

PRESENT EMPLOYER _____

POSITION _____ DATES OF EMPLOYMENT _____

PREVIOUS EMPLOYMENT: List most recent employment first.

Name of Employer	Address (Street, City, State, Zip)	Dates of Employment
_____	_____	_____
_____	_____	_____
_____	_____	_____

(List other employers on a separate page.)

CPR CERTIFICATION FOR A HEALTHCARE PROVIDER or PROFESSIONAL RESCUER IS MANDATORY BEFORE YOUR ACCEPTANCE INTO THE PRACTICAL NURSING PROGRAM.

REFERENCES:

Give the enclosed reference forms to three persons you wish to use for references and list their names below. References from coworkers or employers are preferred, but teachers, counselors or clergy are acceptable. **Do not use relatives or in-laws.**

1. _____ 2. _____

3. _____

HAVE YOU EVER BEEN CONVICTED OF ANY CRIMINAL OFFENSE IN ANY STATE OR IN FEDERAL COURT (OTHER THAN FOR MINOR TRAFFIC VIOLATIONS)? YES _____ No _____

IF YES, PLEASE CONTACT THE COORDINATOR OF THE NURSING PROGRAM BEFORE SUBMITTING THIS FORM.

PLEASE WRITE A SHORT STATEMENT OF WHY YOU WANT TO BE A PRACTICAL NURSE.

I UNDERSTAND THAT FALSE STATEMENTS OR OMISSIONS ON ANY PART OF THE APPLICATION MAY BE CONSIDERED SUFFICIENT CAUSE FOR DENIAL OF ADMISSION OR DISMISSAL FROM THE PROGRAM.

DATE _____ SIGNATURE _____

Accredited by:
The National League for Nursing Accrediting Commission, Inc.
61 Broadway, 33rd Floor
New York, New York 10006
1-800-669-1656

Please send application to:
Capital Area School of Practical Nursing
2201 Toronto Rd.
Springfield, IL 62712

The Capital Area School of Practical Nursing offers practical nursing education opportunities without regard to age, color, race, sex, nationality, religion or religious affiliation, physical limitations/disability or sexual orientation.

REV. 05/06, 01/07,03/07,04/07,05/07,10/07,01/08

CAPITAL AREA SCHOOL OF PRACTICAL NURSING

Authorization for Release of Criminal Background Information
(School Purposes)

TO BE COMPLETED BY STUDENT
(PLEASE PRINT LEGIBLY OR TYPE)

LAST NAME	FIRST NAME	M.	SUFFIX (JR., SR.)
MAIDEN NAME OR OTHER ALIASES _____			
SOCIAL SECURITY Number _____ / _____ / _____			
DATE OF BIRTH _____ / _____ / _____ Month Day Year			SEX: FEMALE MALE
RACE: WHITE ASIAN BLACK HISPANIC PACIFIC ISLANDER UNKNOWN			
CURRENT ADDRESS _____ Street Address			
City	State	Zip	

Student Authorization

Without reservation, I authorize Capital Area School of Practical Nursing (CASPN) to procure my background check to obtain or furnish information concerning my criminal or other history. I understand that inquires may be made to various federal, and state agencies, employers, references, acquaintances and others seeking information as to my personal characteristics, employment status, and general reputation.

Signature _____ Date _____

Print Full Name _____

This information is requested by CASPN for purposes of insuring accurate retrieval of records for acceptance into the nursing program.

TO BE COMPLETED BY CASPN STAFF ONLY	
Date background received _____	CASPN Staff Initials _____

05/07,06/07,05/08

Capital Area Career Center
Capital Area School of Practical Nursing
2201 Toronto Road • Springfield, IL 62712-3803
Phone (217) 585-2160 • 585-2165
www.caspn.org

PERSONAL HEALTH FORM
(TO BE FILLED OUT BY APPLICANT)

NAME _____ AGE _____ DATE _____

DISEASE	YES	NO	AGE
Allergies (specify)			
Asthma			
Back, hip, knee trouble (specify)			
Blood pressure trouble			
Broken bones (specify)			
Diabetes			
Ear, nose, throat trouble (specify)			
Eye trouble (specify)			
Foot trouble (specify)			
Hay Fever			
Headaches			
Head injury			
Hearing loss (specify)			
Heart trouble (specify)			
Hepatitis or Jaundice			
Hernia, rupture			

DISEASE	YES	NO	AGE
Intestinal problems (specify)			
Joint problems: arthritis, etc. (specify)			
Mental illness: depression, manic, obsessive, etc. (specify)			
Paralysis (include Polio or stroke)			
Rubella (German measles)			
Rubeola (Measles)			
Seizures (epilepsy)			
Skin disease (specify)			
Stomach trouble (ulcer)			
Tuberculosis			
Tumor, cyst, cancer (specify)			
STD: Gonorrhea, syphilis, herpes etc. (specify)			
AIDS/ARC/HIV POSITIVE (specify)			
Other chronic disease or illness C.P., M.S., M.D., Lupus, etc. (specify)			
Other illnesses (specify)			

DESCRIBE ANY INJURIES OR OPERATIONS	DATE (APPROXIMATE)	AGE

This PERSONAL HEALTH FORM is to be completed by the applicant and returned with the APPLICATION.

Revised 08/06,01/08

Capital Area School of Practical Nursing

Name _____

Date _____

List all prescription or over the counter drugs you are currently taking. Capital Area School of Practical Nursing must include this information in your health record.

Prescription Drug

What are you taking this for?

Over the Counter

What are you taking this for?

If any medications should change, please notify the office.