



ST. JOSEPH'S HOSPITAL  
*School of Nursing*

Spring, 2010

Dear Applicant,

We are pleased to send you the application information that you have requested. Please complete the enclosed documents, request the transcripts from all schools you have attended and if you had been a student in another school of nursing we require a letter from the director/dean of that program stating the reason/s that you left the program.

If you need additional information please consult our web-site at [www.sjhson.org](http://www.sjhson.org) or call the school at 215 787 2323 to speak to Bill Deane, enrollment manager.

Thank you for your interest in St. Joseph's Hospital School of Nursing. We look forward to working with you to assist you in achieving your goal of becoming a registered nurse.

Sincerely,

*Carole A. Baxter*

Dr. Carole A. Baxter  
Dean, SJHSON

**ST. JOSEPH'S HOSPITAL SCHOOL OF NURSING  
APPLICATION FORM  
2010**

1. Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
2. Maiden or Former Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_
3. Address: Street: \_\_\_\_\_ Apt # \_\_\_\_\_
4. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
5. Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_
6. E-Mail: \_\_\_\_\_
7. Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widow(er) \_\_\_\_\_
8. Spouse Name: \_\_\_\_\_ Number of dependents \_\_\_\_\_

**Personal Information:**

1. U S Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_ If no, do you have permanent resident status? Yes \_\_\_\_\_ No \_\_\_\_\_
2. What is your country of birth: \_\_\_\_\_ Is English a second language? \_\_\_\_\_
3. What language is spoken primarily at home? \_\_\_\_\_
3. Date of birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**St. Joseph's Hospital School of Nursing is seeking to draw students from a culturally diverse population:**

1. Please indicate your ethnic background (optional): Asian \_\_\_\_\_ African American \_\_\_\_\_  
Caucasian \_\_\_\_\_ Hispanic/Latino \_\_\_\_\_ Native American \_\_\_\_\_  
Other (please name) \_\_\_\_\_

**North Philadelphia Health System (NPHS):**

1. Do you or a member of your family work for the North Philadelphia Health System?  
Self: \_\_\_ Family member: \_\_\_ Title: \_\_\_\_\_ How long: \_\_\_\_\_ GMC: \_\_\_ SJH \_\_\_.

**Work Experience:**

List most recent employment first:

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Are you an LPN? \_\_\_\_\_ License Number and State \_\_\_\_\_

Certified Nursing Assistant \_\_\_\_\_ Medical Assistant \_\_\_\_\_

**Education:**

High School: \_\_\_\_\_

Graduation Date: \_\_\_\_\_ GED date if applicable: \_\_\_\_\_

List **all** Colleges or Schools of Nursing attended: (If attended another school of nursing applicant must submit a letter from the Program Director/Dean stating the reason(s) for leaving the program)

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How did you hear about the St. Joseph’s Hospital School of Nursing program?

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All Prerequisite Courses Completed? Yes \_\_\_\_\_ No \_\_\_\_\_

Courses in progress and anticipated date of completion. Use the chart below (C indicates completed, IP indicates in progress, when indicates date that course will be completed)

Prerequisite Courses		C	IP	When
1.	Anatomy/Physiology I (4 Cr)*			
2.	Anatomy/Physiology II (4 Cr)*			
3.	Biology101 (4 Cr)*			
4.	Chemistry 101 (4 Cr)*			
5.	English 101 (3 Cr)			
6.	English 102 (3 Cr)			
7.	Math 101 (3 Cr)*			
8.	Microbiology (4 Cr)*			
9.	Medical Terminology (3 Cr)*			
10.	Psychology (3 Cr)			
11.	Nutrition (3 Cr)*			
12.	Human Growth & Dev. (3 Cr)*			

**Total: 41 College credits**

**\*These college credits must have been awarded less than 10 years ago and must be completed by July 1, 2010. Others courses must be completed with an official transcript on file by the first day of class.**

I certify that the information submitted in this application is complete and correct and, I understand that any misrepresentation of information or omission of fact in this application may result in the denial or revocation of an admission.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Non-refundable application fee \$150.00.

Please make Bank Check or Money Order payable to St. Joseph’s Hospital School of Nursing. Also you may use a credit card by coming to our office.

Please note: All submissions become property of SJHSON and will not be returned to the applicant. Records are destroyed after three (3) years.

## **Application Instruction Sheet:**

### **Submit all of the following in order to complete the Application Process**

- **Completed Application Form**
- **Application fee (non-refundable)**
- **All official transcripts (including official high school transcript)**
- **Reference Letters (2)**
- **Background Checks (2)**
- **Drug Screen results**
- **Scores of HESI Admission Assessment Test**

### **References:**

Two letters of reference from community leaders, educators or employers on letterhead are required. Letters are considered confidential and the person completing the reference must sign and mail it to Bill Deane on letterhead and be signed. References from relatives and peers are not acceptable. Give Confidential Letter of Recommendation form to each person that you have selected to provide reference.

### **Background Check:**

The following must be submitted and meet the requirements set forth by the Pennsylvania State Board of Nursing (PSBON)

- Criminal History Record Information (CHRHI) without ACT 14 prohibitive (apply on line or call 877-777-3375)
- Child Abuse Clearance Records (CACR- call 1-717-783-6211) must be submitted and meet requirements set forth by the Pennsylvania State Board of Nursing (PSBON).
- In addition, all applicants are required to provide an FBI background check regardless of state of residence. This site provides the information that the applicant will need to obtain this documentation. [http://www.pa.cogentid.com/index\\_dpw.htm](http://www.pa.cogentid.com/index_dpw.htm) or applicant may contact: Cogent Systems, 5450 Frantz Rd. Dublin, OH 43016 for further information. Or applicant may e-mail questions to: [pahelp@congentsystems.com](mailto:pahelp@congentsystems.com). The service is \$36.

### **Drug Screen:**

Applicants must obtain drug a screen from the agency below. The cost is \$50 and is the responsibility of the applicant. The results will be sent directly to SJHSON from the agency.

Industrial Health Care Center  
Phone: 215677-0930 (Philadelphia)  
2804 Southampton Rd.  
Philadelphia, PA 19154  
Website: [www.industrialhealthcare.com](http://www.industrialhealthcare.com)

**Minimum Health Requirements:**

Students will be required to submit all pre-entrance Medical History Evaluation and Assessment Summaries prior to entry into the program. Applicant is responsible for the cost of all physical examinations and reports. The physical form is attached to the application packet or can be e-mailed/mailed to you upon request. Please e-mail requests to Rosalind Jefferson at [rjefferson@sjhson.org](mailto:rjefferson@sjhson.org) or applicant may pick one up at the school. Any questions may be directed to Judy Martin, Student Services Coordinator, at 215-787-2323. Send results of health requirements to Judy Martin, Student Services Coordinator, St. Joseph's Hospital School of Nursing, 801 Girard Ave. Philadelphia, PA 19122.

**Transcripts:**

You must request official transcripts for all schools (including H.S.) you have attended and they must be sent directly to SJHSON. Applications received after July 1, 2010 will not be considered for the 2010 class.

**Personal Interview:**

A personal interview may be scheduled if all requirements are met. The interview does not guarantee acceptance into St. Joseph's Hospital School of Nursing

**Mail Application Materials to:**

St. Joseph's Hospital School of Nursing  
Enrollment Management - Attn. Bill Deane  
801 West Girard Avenue  
Philadelphia, PA 19122

**CONFIDENTIAL LETTER OF RECOMMENDATION:**

**Recommender, please return this form with your signed letter of recommendation on letterhead.**

**Date:** \_\_\_\_\_

**Applicant's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Recommenders Instruction and Information**

The above student is applying for admission into the diploma nursing program here at St. Joseph's Hospital School of Nursing. Upon graduation the graduate will be permitted to take the National Council Licensure Examination (NCLEX) and become a registered nurse (R.N.). We are interested in what you have to say about their personal, work and or scholarly attributes. Self directed qualities, good study skills, the ability to focus, motivation, and decision making capabilities are critical elements to the success in meeting the retention and graduation requirements of students who are applying to the professional nursing education program. Your recommendation of the applicant will be an integral component of the acceptance process.

**Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Reference's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Relationship to the Applicant:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

Recommendations should be returned as soon as possible to:

St. Joseph's Hospital School of Nursing  
Enrollment Management - Attn. Bill Deane  
801 West Girard Ave.  
Philadelphia, PA 19122

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Recommendations should be returned as soon as possible to:

St. Joseph's Hospital School of Nursing  
Enrollment Management - Attn. Bill Deane  
801 West Girard Ave.  
Philadelphia, PA 19122



*\*Note: Drug testing is required at the time of application. The cost is \$50.*

**Industrial Health Care Center**

Phone: (215) 677-0930 – Philadelphia  
2804 Southampton Rd, Philadelphia 19154  
Website: [www.industrialhealthcare.com](http://www.industrialhealthcare.com)

**Immunizations**

The student must present evidence of the following immunizations or immunity for the following in compliance with requirements of North Philadelphia Health System:

- Evidence of immunity or immunization to Measles, Mumps, and Rubella (MMR) since 1980
- Diphtheria/Tetanus (DT) (Must be within ten years).
- Polio (Titer may be deferred after consultation with Coordinator of Student Services)
- Hepatitis B completed series or Antibody Titer
- Hepatitis A IGM
- Hepatitis C Antibody Titer
- Varicella immunization or IGG
- 2 step PPD or chest x-ray if PPD positive or BCG given.

I certify that the information on this form is true, correct and to the best of my knowledge complete. I am aware that the information provided is voluntary and is strictly confidential.

This information becomes the property of St. Joseph’s Hospital School of Nursing and will be maintained in a confidential manner by St. Joseph’s Hospital School of Nursing. It may not be released without my written consent.

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 B/P: \_\_\_\_\_ Pulse (Apical): \_\_\_\_\_  
 Color Vision: \_\_\_\_\_ Vision OD20/ \_\_\_\_\_ Corrected: \_\_\_\_\_  
 OS 20/ \_\_\_\_\_ Corrected: \_\_\_\_\_  
 Hearing: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Hearing Aid \_\_\_\_\_  
 If abnormal: Right Left Both (Circle one)

	Normal	Abnormal	Details of Abnormality
1. Head, Neck, Face and Scalp			
2. Nose and Sinuses			
3. Teeth and Mouth			
4. Ears (per. of drum etc.)			
5. Eyes (lids, conjunctiva etc.)			
6. Pupils and ocular motion			
7. Lungs, chest and breast			
8. Heart			
9. Vascular system			
10. Abdomen and viscera			
11. Ano-rectal			
12. Endocrine System			
13. Genito-urinary system			
14. Upper extremities			
15. Lower extremities			
16. Reproductive			
17. Spinal, other musculoskeletal			
18. Integumentary			
19. Neurological			
20. Psychiatric/Mental disorders			
21. Breathing or allergies			

**\*Please Fill in and Attach ALL results\***

Chest X-Ray: \_\_\_\_\_ EKG \_\_\_\_\_ Other \_\_\_\_\_

Lab Data: CBC: \_\_\_\_\_ Urinalysis \_\_\_\_\_ Blood Glucose \_\_\_\_\_

PPD Results #1 \_\_\_\_\_ PPD Results # 2 \_\_\_\_\_

Hepatitis B Virus Vaccination Series: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Hepatitis B Titer results if applicable \_\_\_\_\_

I have on this date examined this patient and, on the basis of the examination requested by St. Joseph's School of Nursing authorities and the patient's health history furnished to me, and have found no reason that would make it medically or emotionally inadvisable for this patient to perform all activities in the capacity of a student nurse.

Cleared: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Cleared after recommendations for: \_\_\_\_\_

If not cleared, give reasons: \_\_\_\_\_

\_\_\_\_\_

Recommendations: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Office location: \_\_\_\_\_

Name of Examiner (Print): \_\_\_\_\_

Examiner's Signature: \_\_\_\_\_ License Number: \_\_\_\_\_

**Please provide official stamp:**

If the Physician Assistant (PA) or Advanced Nurse Practitioner (APN) performed the examination, the name(s) and address of the collaborating physician or physician group should be placed below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mail Materials to:**  
**Judith Martin RN, BS (Coordinator of Student Services)**  
**St. Joseph's Hospital School of Nursing**  
**801 Girard Ave**  
**Philadelphia PA 19122**  
**215 787 2323 ext 408**