



ST. JOSEPH'S HOSPITAL
School of Nursing

Fall 2011

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 or call the school at 215 787 2323 X415 to speak to Betty Schanne, 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**

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:

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)

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

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, which 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.	Chemistry 101 (4 Cr)*	_____	_____	_____
4.	English 101 (3 Cr)	_____	_____	_____
5.	English 102 (3 Cr)	_____	_____	_____
6.	Math 101 (3 Cr)*	_____	_____	_____
7.	Microbiology (4 Cr)*	_____	_____	_____
8.	Medical Terminology (3 Cr)*	_____	_____	_____
9.	Psychology (3 Cr)	_____	_____	_____
10.	Nutrition (3 Cr)*	_____	_____	_____
11.	Human Growth & Dev. (3 Cr)*	_____	_____	_____

Total: 37 College credits

***These college credits must have been awarded less than 10 years ago and must be completed before starting the nursing program. 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. You may also 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 Kaplan “Admission” 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 Dr. Carole Baxter on letterhead with signature. 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 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. 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

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 Dr. Carole Baxter cbaxter@sjhson.org or applicant may pick one up at the school. Any questions may be directed to her.

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 August 1, 2011 will not be considered for the 2011 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
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
801 West Girard Ave.
Philadelphia, PA 19122

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St. Joseph's Hospital School of Nursing
Enrollment Management
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

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:
Enrollment Management
St. Joseph's Hospital School of Nursing
801 Girard Ave
Philadelphia PA 19122
215 787 2323 ext. 408**