



**PERSONAL INFORMATION:**

Last name: \_\_\_\_\_ First: \_\_\_\_\_ M.I: \_\_\_\_\_

Maiden name: \_\_\_\_\_ SS #: \_\_\_\_\_ Banner ID: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Street or P.O Box: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_

**EDUCATIONAL INFORMATION:**

**Name of high school and date of high school graduation:** \_\_\_\_\_

**Colleges attended (Attach official transcripts for all colleges attended)**

1. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

4. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

5. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

6. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

**HEALTHCARE- RELATED WORK EXPERIENCE:**

LIST HEALTHCARE-RELATED WORK AND/OR COLUNTEER EXPERIENCES. (YOU MUST ATTACHED SKILLS VERIFICATION SHEET AND RESUME WITH THIS APPLICATION.)

1. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_

4. \_\_\_\_\_ Date: \_\_\_\_\_ City/State: \_\_\_\_\_



## SIGNATURES

I affirm that all information on this application is true. I understand that it is fraudulent to misrepresent any information on this form, and discovery of misinformation will affect my ability to be admitted to or allowed to continue in the University of New Mexico-Valencia Campus Nursing Program. I also acknowledge receiving a copy of the Nursing Program Selection Committee Policy number 100.1 and understand my responsibilities as an applicant/student and the Nursing Admission Selection process.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Other items *that must* accompany this form are:

- Transcripts from other higher educational institutions attended; the most recent UNM-VC transcript (showing that you achieved a "C" or better in all your pre-requisites)
- Proof of certified nursing assistant or certification or proof of experience in another health-related field
- Current CPR card for Health Related Professionals (or documentation showing you've signed up for CPR class)
- TEAS Examine Scores, testing dates posted on <http://www.unm.edu/~unmvc/Nursing/nursingprogram.html>
- Healthcare Related work experience Sheet (*if applicable*)
- Two page, double spaced essay, APA format (Why you wish to be accepted, why you believe you will be successful and what future contributions do you hope to make to the profession?)
- If requesting additional point for Veteran Status you must attach your DD-214.
- If you are requesting an additional point as Valencia County Resident you must provide current proof of residency (a bill -Electric, gas, water, garbage, cable) which was mailed to your current address, with your full name (first and last) will serve as sufficient proof.
- Health Examination Form (attached).
- Applicant must acquire fingerprinting for both state and federal background check. Background check will be submitted by the institution at the time of submission (Cost \$65.00, Money order for the Division of Health Improvement).
- Include updated resume with pertinent supervisor contact information (work history verification).

Staple all materials together and mail to or bring the materials to: The Nursing Program Coordinator Jennifer Abers 280 La Entrada, Los Lunas, NM 87031 505-925-8870.

Approved 1/25/2011



**Nursing Program Student Entrance Health Examination Form**

Print this form and take to physician or nurse practitioner.

**To be completed by student:**

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

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Current Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

Past or Present Diseases/Illnesses:

IMMUNIZATIONS			
Date of PPD ⇒	___/___/___	___/___/___	___/___/___
Results of PPD ⇒			
<b>MMR X 2</b>			
Dates #1:	___/___/___	#2:	___/___/___ or
Measles vacc. date:	___/___/___	or titer results:	<input type="text"/>
Mumps vacc. date:	___/___/___	or titer results:	<input type="text"/>
Rubella vacc. date:	___/___/___	or titer results:	<input type="text"/>
Hepatitis B series:	___/___/___	___/___/___	___/___/___
Tetanus (q10yrs)	___/___/___	___/___/___	
Varicella (verbal or titer)	___/___/___		

**To be completed by healthcare provider:**

Significant Medical History:

Do you consider this individual in suitable physical and emotional health for nursing school? YES NO

If no, why not?

Healthcare provider's printed name:

Healthcare provider's signature:

Clinic or hospital location (where exam took place):

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Telephone: Day ( ) Cell: ( ) Message: ( )