Application Checklist

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Declaration of Intent Completed
* Self-Evaluation Completed
* Clinical Student Disclosure Statement Completed
* Assured Access to Computer Completed
* Unofficial Transcript from LSSU
* Unofficial Transcripts for all transfer credits (attached)
* Additional Advising Received (International travel, full-time coursework, etc.)

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

Academic Advisor/Dean (signature) Date

✂-----------------------------------------------------------------------------------------------------------------

Received By (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**DECLARATION OF INTENT FOR ADMISSION TO RN to BSN PROGRAM**

**\*\*Please attach a copy of your RN license\*\***

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print) First Name Middle Name Last Name Maiden Name or other names used

wish to have my student file(s) evaluated for admission to the Lake Superior State University BSN Program that I

have noted above. By signing my name below, I attest to the accuracy of the information provided in this application

packet and am aware that the School of Nursing will begin the screening process.

Student Signature: Date:

LSSU/Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Best Telephone Number to Contact Me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

LSSU Student ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have attended other universities/colleges, please list them below.**

Educational History Date(s) of Attendance

High School:

College(s)/University(ies)

***Self-Evaluation for Admission to the Nursing Programs at LSSU***

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. These personal attributes are critical for all nursing students at LSSU. Please rate yourself on each of the following Characteristics:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Characteristic | Rating | | | |
| Punctuality | Excellent | Good | Fair | Poor |
| My level of preparation for performance | Excellent | Good | Fair | Poor |
| My level of follow through with commitments | Excellent | Good | Fair | Poor |
| Oral communication skills | Excellent | Good | Fair | Poor |
| Written communication skills | Excellent | Good | Fair | Poor |
| Social Appropriateness | Excellent | Good | Fair | Poor |
| Dependability | Excellent | Good | Fair | Poor |
| Integrity | Excellent | Good | Fair | Poor |
| Common Sense | Excellent | Good | Fair | Poor |
| Quality of work | Excellent | Good | Fair | Poor |
| Judgment | Excellent | Good | Fair | Poor |
| Initiative | Excellent | Good | Fair | Poor |
| Accountability | Excellent | Good | Fair | Poor |

1. What specific strengths do you have that make you a good candidate for LSSU’s nursing program?
2. In the table below, list the name of all faculty members (preferably LSSU faculty members) you have had in all courses taken and provide their phone number.

|  |  |  |
| --- | --- | --- |
| Course | Faculty Member | Phone Number |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. By signing the line below, I am allowing the School of Nursing Application Committee to contact any faculty I have had.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Student Disclosure Statement - To Be Retained by the Educational Institution

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational Institution Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Training Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I certify that I have not been convicted of a crime or offense that prohibits me from being granted clinical privileges in a long-term care setting as required by P.A. 27, 28 and 29 of 2006 within the applicable time period prescribed by each time.

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

Signature of Student Date

1. I certify that I have not been the subject of an order or disposition under the Code of Criminal Procedure dealing with findings of “not guilty by reason of insanity” for any crime.

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

Signature of Student Date

1. I certify that I have not been the subject of a state or federal agency substantiated findings of patient or residential neglect, abuse or misappropriation of property or any activity that caused my nurse aide certification to be “flagged”.

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

Signature of Student Date

1. I have listed below all offenses for which I have been convicted, including all terms and conditions of sentencing, parole and probation and any substantiated finding of patient or resident neglect, abuse or misappropriation of property.

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

Signature of Student Date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Conviction/Offense | Date of  Conviction/Finding | City | State | Sentence | Date of  Discharge |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. I certify that I have reviewed the list of prohibited offenses as defined in P.A. 27, 28 and 29, and that the above list of my convictions and/or substantiated findings of patient or resident neglect, abuse or misappropriation of property (if any) is true, correct and complete to the best of my knowledge. I also understand that if the information is not accurate or complete, my clinical privileges will be withdrawn immediately. I understand that the facility or educational program denying my privileges based on information retained through a background check is provided immunity from any action brought by a student due to decision to remove clinical privileges.

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

Signature of Student Date

**Assured Access to Computer Agreement**

There may be times in the course of your nursing program that coursework will be offered to you in an online format. To assure your success with this medium, it is essential for you to have appropriate access to the following:

The **Assured Access to Computer Agreement (AACA)** requires the following:

* Reliable access to a computer with minimum system requirements\* and the Internet when taking online courses
* Students who do not own a computer must be prepared to allocate time for working in campus computer labs, libraries, or any public or private use venue.
* The AACA does not assume students will purchase computers, but it does require reliable access to them for purposes of online assignments and interaction.

Please sign below to affirm that you have read and understand the **Assured Access to Computer Agreement (AACA**) and that you have assured access to a computer and the Internet.

I have read and understand the AACA, and I affirm that I have assured access to a computer and the Internet.

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

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

LSSU E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Contact LSSU’s IT Department 906.635.6677 for current minimal computer, internet and hardware requirements.