Graduate Nursing Program
Department of Nursing
College of Professional Studies

Graduate Nursing Application

PROGRAM INTEREST *(Please Check)*

__ ***Family Nurse Practitioner*** __ ***Nurse Educator*** __ ***Southern Maryland Program***

___***Full Time*** ___***Part Time***

PERSONAL INFORMATION *(Please type or print)*

Name: _____

Social Security Number: _____ Date of Birth _____

Permanent Address: _____

City/ State/ Zip Code: _____

Current Address: (if different from permanent address): (Include No., Street, City, State, & Zip)

_____

Home Phone Number:_____ Cellular Phone Number:_____

Business Phone Number: _____ Fax Number: _____

E-mail Address: _____

Country of Birth: _____ Country of Citizenship: _____

Are you currently a member of the United States Armed Forces? ☐Yes ☐No
If yes, what branch? _____

Do you have any disabilities that will require special accommodations? ☐Yes ☐No
(If yes, please explain):

_____

_____

CITIZENSHIP STATUS

U.S. Citizen (Yes or No) _____ Permanent Resident Alien _____ Refugee _____ Asylee _____

Other: _____(Attach a copy of your alien registration card.)

Is English your first language? Yes __ No__ (If no, what language): _____

EDUCATIONAL BACKGROUND

List in chronological order all colleges or universities previously attended, including all specialty schools or programs. (Start with the most recent college attended. Write on the back of this form if necessary.)

College/Universities Attended Location Dates Attended Degree or Certificate

_____

_____

EMERGENCY CONTACT INFORMATION

Please provide the name of an individual that we may contact in case of an emergency:

Name:_____

Relationship: _____

Address: _____

Phone Number: _____

LICENSURE

Number: _____ State: _____ Expiration Date: _____

CURRENT CERTIFICATION

Specialty: _____ Number: _____ Expiration Date: _____

EMPLOYMENT

Current Employer: _____

Area of Practice: _____

Work Schedule: *Full-Time*:_____ *Part-Time:* _____ *Flex-Time:* _____

BIOSTATISTICAL INFORMATION

The following information will be kept confidential. The information you provide will be used only for statistical purposes.

Age: _____

Gender: ☐Male ☐Female

Ethnicity: ☐African-American ☐African ☐American Indian or Alaskan ☐Asian-American

☐Latin-American ☐Caucasian ☐Other: (Specify) _____

Have you previously earned an undergraduate degree? ☐Yes ☐No

(If yes, where?):_____

To the best of my knowledge, the information furnished in this application is complete, true and correct. I understand that falsification or any misrepresentations of my qualifications may result in the denial of my admission application or dismissal from the program if admitted. I agree that if admitted to Bowie State University's Nursing Program, I will, during such time as I may be enrolled as a student, abide by all the rules, regulations, practices, and policies of Bowie State University.

Signature: _____ **Date:** _____

(Applications to the Department of Nursing at Bowie State University are considered for admission without regard to race, color, religion, gender, nation of origin, age, disability or veteran status.)

*As a reminder, candidates must receive general graduate admission to Bowie State University to be eligible for graduate nursing admission.

Please forward your completed application and all requested documents to:

Attn: Mr. Kenneth Dovale, Academic Advisor
Department of Nursing: Graduate Nursing Admission
Center for Learning and Technology, Room 202
Bowie State University
14000 Jericho Park Road
Bowie, Maryland 20715

BOWIE STATE UNIVERSITY
Department of Nursing

Physical Examination/Health History Form

Physical examinations must be completed by a licensed health care provider (MD, NP, or PA). Students must complete section A of this form. Section B must be completed by a Health Care Provider. *(This information is strictly for the use of the Department of Nursing for health clearance and will not be released to anyone without your knowledge.)*

Section A. **(Please print or type)**

Last name	First name	MI	Soc. Sec. #	Gender

Home Address	City	State	Zip Code
County			

Date of Birth	Place of Birth	(Area Code) Home Phone

Emergency Contact: _____ Phone #:_____

Relationship:_____

Current and active Health Insurance is required for all Nursing Students. Please list your insurance carrier:

_____

Immunization History:

Polio Series completed as a child: Yes:___ No:____ Comment: _____

DPT Series completed as a child: Yes:___ No:____ Comment: _____

Date of last Tetanus Booster (must be within 10 years): _____

Date of MMR **1st Dose:** _____ **2nd Dose**: _____ *or* **Titer Results**: _____

Hepatitis B Series 1st Dose: _____ **2nd Dose**: _____ **3rd Dose**: _____

Varicella (Chicken Pox) **Immunization:** Date: _____*or* **Titer Results:**_____

H1N1 Immunization: Date: _____

Are there any significant health problems of which the Department of Nursing should be aware (include any disabilities, mental illness, substance abuse, etc.)? If yes please explain:

_____
_____
_____
_____

Current Health Status

BP _____ Pulse _____ Height _____ Weight _____

Vision: Right 20/ _____ Left 20/ _____

PPD: Date _____ Result _____ OR CXR: Date _____ Result:_____

Are you allergic to any medicines? Yes ____ No _____

(If yes please list)_____

Other allergies_____

Past Hospitalizations _____

Other illness or injury _____

Students: Please comment on any history of abnormality in the below systems.
Health Care Providers: Please indicate assessment results.
Please explain all abnormal findings in comments below.

(WNL = Within Normal Limits, ABN = Abnormal)

System	WNL	ABN	WNL	ABN
1. Skin				
2. Eyes				
3. Ears				
4. Nose				
5. Throat				
6. Respiratory				
7. Endocrine				
8. Cardiac				
9. Gastrointestinal				
10. Urinary				
11. Musculoskeletal				
12. Neurological				
13. GYN				

Comment:_____
_____
_____
_____

To the best of my knowledge this person is mentally capable of caring for clients in the clinical setting. Yes: _____ No: _____

Health Care Provider (*Print*): _____ Date:_____

Address: _____ Phone: _____

This form has been completed truthfully to the best of my knowledge.

Signature of Health Care Provider: _____ Date: _____

Signature of Student: _____ Date: _____

Revised: 4/20/10: BEJ

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APPLICANT RECOMMENDATION FORM

PART A. *(To be completed by the applicant)*

Name: _____
Last First Middle Initial

Place of Employment: _____

Title of Position: _____ Date of Hire: _____

PUBLIC LAW 93-380: Educational Amendments Act of 1974, grants students the right of access to letters of recommendation in their placement files.

PART B. (*To be completed by the recommender)*

Name of Recommender: _____

Place of Employment: _____

How long and in what capacity have you known the applicant?

_____

_____

_____

We would like your assessment of the applicant's potential for continued study in nursing. Please address each of the identified area listed below in terms of strengths or weaknesses. If you have not had adequate opportunity to evaluate this person in the identified areas, please indicate. Please place a "✓" mark to indicate your response.

Criteria	5- Strong	4	3-Average	2	1-Weak	Not Observed
Quality of nursing practice						
Management skills						
Communication skills (oral)						
Communication skills (written)						
Ability to work with others						
Maturity						
Leadership qualities						
Intellectual potential						

Based on your observations in the practice setting, describe the areas of strength and areas needing growth for this applicant.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please indicate the strength of your endorsement by placing a check mark (✓) in the appropriate box.

Not Recommended ☐	Recommended with some reservations ☐	Recommended ☐	Highly recommended ☐

Signature: _____

Printed Name: _____ *Date:* _____

Title and Position: _____

Name of Company or Place of Business: _____

Address of Business: _____

_____