



Accelerated Nursing Program
Department of Nursing
College of Professional Studies

Accelerated BS in Nursing Program Application

PERSONAL INFORMATION (Please type or print)

Name: _____

Social Security Number: _____ Date of Birth _____

Permanent Address: _____

Home Phone Number: _____ Cellular Phone Number: _____

Business Phone Number: _____ Fax Number: _____

E-mail Address: _____

Country of Birth: _____ Country of Citizenship: _____

Citizenship Status: U.S. Citizen ___ Nonimmigrant Alien (Visa type) _____

Is English your first language? Yes ___ No___ If no, what language: _____

How many hours do you work each week? _____

Do you have sole responsibility for dependents? yes ___ no ___ How many? _____

PROGRAM INFORMATION

Have you previously applied to this nursing program? Yes No

If yes, when? _____(Semester / Year)

Have you previously attended another nursing program? Yes No

If yes, when? _____(Semester / Year)

EDUCATIONAL BACKGROUND

List in chronological order all colleges or universities previously attended, including all specialty schools or programs. (Start with the most recent college or school 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: _____

Moral Background

Have you ever had any legal criminal charges or complaints brought against you? **Criminal Background checks are mandatory.**

N _____ Y _____

Do you have any drug or alcohol use that may interfere with performance in classroom or clinical areas?

N _____ Y _____

Do you have any type of discipline or action on a license such as CNA/GNA or LPN? **

N _____ Y _____

**** Please note that interested students answering YES to this question are advised to seek information from the Maryland Board of Nursing regarding permission to obtain another license.**

Biostatistical Information

The following information is voluntary and confidential. The information you provide will be used only for statistical purposes.

Gender: Male Female

Marital Status: Single Married Divorced Widowed Separated

Ethnicity: African American
 African
 American Indian or Alaskan
 Asian American
 Latin American
 Multiracial
 White or Caucasian
 Other: Specify _____

Are you a Veteran? Yes No If yes, what branch of the armed forces? _____

Date of Discharge? _____

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

Do you speak a language other than English? _____

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, you must receive confirmation of admission to Bowie State University, prior to applying for admission to the nursing program.

Please forward your completed application and all requested documents to:

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