

SHARON REGIONAL HEALTH SYSTEM SCHOOL OF NURSING

APPLICATION FOR ADMISSION

Sharon Regional Health System
School of Nursing / Admission Committee
740 East State Street, Sharon, PA. 16146
(724) 983-3865 Fax: (724) 983-5621
www.sharonregional.com

* Applicants are selected without regard to race, religion, gender, marital status, national origin, age, or disability. Admission to this program is at the discretion of the School of Nursing Admission Committee. Special consideration may be given to employees of Sharon Regional Health System.

PRINT OR TYPE ALL INFORMATION BELOW

Date: _____ Home Phone # _____

Name: _____
(First) (Middle) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Work Phone #: _____

Have you ever worked or attended School under another Name? No ___ Yes ___ If yes, Please state the name _____

Emergency Contact Information

Contact Person's Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Post - Secondary Education

Name of School	City & State	# of Credits Earned	Degree Earned	Years Attended

1. How did you learn about Sharon Regional Health System School of Nursing?

Previous Graduate: _____ Billboard: _____ Current Student: _____ Newspaper Ad: _____
High School Counselor: _____ Open House: _____ Career Fair: _____ Other-Specify: _____

2. Have you previously applied for admission to this School? No: _____ Yes, What year: _____

3. Have you previously attended this School or any other School of Nursing? No: _____ Yes, What year: _____

What was your reason for withdrawing? _____

When do you desire to enter our nursing program? _____

REFERENCES

*** Please note that you will be required to submit three (3) references from the following sources:

1. Work / Professional
2. Academic
3. Character

* Do not choose relatives or close friends. The reference forms are included in this packet with instructions stating they are to be mailed by those supplying the information to the address above.

EMPLOYMENT – Start with Present or Most Recent Employer

Dates Employed (Mo. & Yr) _____
From: _____ To: _____ Employer's Name & Address: _____
Supervisor's Name, Title & Phone #: _____
Title of Job & Duties: _____ _____
What do you (or did you) like best about this position? _____ _____ _____
What do you (or did you) like least about this position? _____ _____ _____
Reason you left or are leaving this position? _____

Dates Employed (Mo. & Yr) _____
From: _____ To: _____ Employer's Name & Address: _____
Supervisor's Name, Title & Phone #: _____
Title of Job & Duties: _____ _____
What do you (or did you) like best about this position? _____ _____ _____
What do you (or did you) like least about this position? _____ _____ _____
Reason you left or are leaving this position? _____

Dates Employed (Mo. & Yr) _____
From: _____ To: _____ Employer's Name & Address: _____
Supervisor's Name, Title & Phone #: _____
Title of Job & Duties: _____ _____
What do you (or did you) like best about this position? _____ _____ _____
What do you (or did you) like least about this position? _____ _____ _____
Reason you left or are leaving this position? _____

EDUCATIONAL DATA

Course (s) liked best: _____ Why? _____

Least: _____ Why? _____

Did your grades represent your best achievements or could you have done better? _____

List extra-curricular activities & achievements, honors that you believe might further qualify you: _____

Which of these activities do you feel you got the most from? _____ Why? _____

ADDITIONAL DATA

List (3) things you have done that you are most proud of (work or non-work) and why?

1. _____

2. _____

3. _____

What appeals to you about working in the health care field? _____

What plans do you have for the future? _____

What have you already done to make these plans work out? _____

What are you currently planning to do to see that these plans work out? _____

What do you consider to be your personal strengths? _____

What is your typical way of dealing with conflict? Give an example _____

What magazines do you commonly read? _____

ADDITIONAL DATA - cont.

<p>What books have you recently read? _____</p> <p>_____</p> <p>_____</p>
<p>What hobbies or recreational interests are you involved in? _____</p> <p>_____</p> <p>_____</p>
<p>List any civic or community activities and offices held? _____</p> <p>_____</p> <p>_____</p> <p>_____</p>

**If you have been convicted of a felony or a crime of moral turpitude,
read the following statement very carefully:**

The “Professional Nursing Law” of Pennsylvania (No. 1985-109, Section 6) specifies that applicants for licensure to practice nursing may be denied a license or privilege of sitting for the licensing examination if they have been convicted of a felony or a crime of moral turpitude. Personal concerns regarding this position should be directed to the State Board of Nursing in Harrisburg, Pennsylvania. Telephone number (724) 783-7142, before completing this application

DECLARATION STATEMENT:

I _____, hereby apply for entrance into SRHS School of Nursing. I agree to make myself available for interviews in regard to this application. I understand that I have the burden of producing adequate information for proper evaluation of this application and failure to produce adequate information will prevent the application from being evaluated or acted upon.

In filing this application, I declare the answers are true and understand that misrepresentation or omission of the facts whether intentional or not, shall be sufficient cause for automatic and immediate rejection of this application. In the event that approval has been granted prior to the discovery of such misrepresentation or omission, such discovery may result in reversal of the approval decision.

I hereby authorize SRHS School of Nursing and its designees to make whatever inquiries it deems necessary of any person or organization that is not a consumer-reporting agency to verify any of the information given in this application. I have the responsibility to keep this application current by informing the School of Nursing, through the Director, of any change in the area of inquiry. I specifically authorize the School of Nursing to consult any third party who may have information, including otherwise privileged or confidential information bearing on my qualifications, credentials, competence, character, or any matter bearing on satisfactorily meeting criteria for acceptance into SRHS School of Nursing.

Date: _____

Signature: _____

Print Name: _____

Parent/ Guardian Signature: _____
(If under 18 years of age)

Date: _____