New Mexico State University Carlsbad
Nursing Program Application Packet

Spring 2013
For Fall 2013 Admission/Re-admission
NURSING PROGRAM APPLICATION

Thank you for your interest in the NMSU-C Nursing Program. Nursing is a demanding discipline. We urge you to recognize the commitment that is essential for one to be successful in this program. Prior to making application to the program, individuals should consider carefully the mental and physical demands of the program and unique pressures involved in successful completion of the nursing certificate/degree.

Begin your application as soon as possible to ensure that you meet all the requirements by the deadline. **There will be no late applications accepted.** Meeting the minimum requirements for admission is no guarantee that you will be accepted. All applications are reviewed and approved by the Admission, Progression, and Graduation (AP&G) committee. Notification letters are mailed out to the address of record on the application by June 21, 2013.

In order to consider your application, the following items must be submitted with your completed packet:

- Current Degree Audit
- Copy of ACT scores that includes scores for Reading, English, Math, Science, and Composite
- Evidence of submitted Background Check – Clearance must be documented by first day of Fall 2013 semester. **Forms and fingerprint cards are available in the Nursing Administration Office.**
- Documented evidence of all required Immunizations and/or Titers with the exception of:
  - TB – this test will be completed during your orientation
  - Hepatitis B – First dose of the series must be documented with application submission. Series must be completed by first day of Fall 2013 semester
- If you do not meet admission criteria, or are applying for re-admission and would like consideration, please submit a letter of request to the AP&G committee.

In addition, you will need to schedule an advising appointment. Please contact the Nursing Administration office at 575-234-9300 to schedule that appointment. The attached checklist will assist you in completing your requirements prior to submission. If you have any questions, you may contact the office or your advisor.

*Application and all required documents due No Later Than 5pm May 15, 2013.*
Nursing Program Application Spring 2013

NEW MEXICO STATE UNIVERSITY CARLSBAD

Nursing Program

APPLICATION FOR ADMISSION TO THE NURSING PROGRAM

NAME: ________________________________________________________________

(Last)  (First)  (Middle)  (Maiden)

ADDRESS: ____________________________________________________________

(No. and Street)  (City and State)  (Zip Code)

Telephone: _______________  SS#: _______________  E-mail ___________________

Have you taken the ASSET/COMPASS placement test?  Circle one:  Yes  No

Date ASSET/COMPASS scores submitted to the nursing office:  __________

Date ACT test taken:  __________  What was your ACT test composite score?  _____

Date CNA class was completed:  _______  Where CNA class was taken:  ________________

Did you take chemistry in high school?  ______  If so, what was your semester grade?  _____

Name of High School:  ___________________________  Date of Graduation:  _______

G.E.D:  ___________________  Date of G.E.D:  ____________________

Circle curriculum option for which application is made:  RN  PN

I certify all of the above statements are correct and complete:

SIGNATURE: _______________________________  DATE: ____________

ADMISSION AND FALL RE-ADMISSION APPLICATIONS ARE DUE MAY 15. No applications will be accepted unless accompanied by copies of high school and college transcripts and ACT scores. SPRING RE-ADMISSION APPLICATIONS ARE DUE NOVEMBER 15.

Prior to submitting this application, if you have ever been convicted of a felony or declared mentally incompetent, you should contact the Board of Nursing in the state in which you intend to seek licensure.
Immunization Record/Infectious Disease Summary

Part I-To Be Completed By Student

**Please bring a copy or childhood immunization records to your appointment**

Name: ____________________________________________________________________________________

Last First Middle

Date of Birth: ____________________ Social Security #: __________________ Phone: ______________

Address: __________________________________________________________________________________

Street City State Zip Code

Part II-NMSU-C Nursing Program Requirements

**TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (dates must include month, day, & year**

Measles (Rubeola)

1. Documentation of two immunizations given after 12 months of age: ____/____/____, ___/____/____

OR

Month Day Year Month Day Year

2. Rubeola antibody titer IgG proving immunity (copy of lab report required): ___/___/___, ___/___/___

Date of Booster, if needed

Month Day Year Month Day Year

Mumps

1. Documentation of two immunizations given after 12 months of age: ____/____/____, ___/____/____

OR

Month Day Year Month Day Year

2. Mumps antibody titer IgG proving immunity (copy of lab report required): ___/___/___, ___/___/___

Date of Booster, if needed

Month Day Year Month Day Year

Rubella

1. Documentation of two immunizations given after 12 months of age: ____/____/____, ___/____/____

OR

Month Day Year Month Day Year

2. Rubella antibody titer IgG proving immunity (copy of lab report required) ___/___/___, ___/___/___

Date of Booster, if needed

Month Day Year Month Day Year

Tdap

1. Tdap (Adacel) ____/____/____

2. Tetanus-diphtheria booster ____/____/____

Month Day Year

Varicella

1. Documentation of two immunizations given after 12 months of age: ____/____/____, ___/____/____

OR

Month Day Year Month Day Year

2. Varicella antibody titer IgG proving immunity (copy of lab report required) ___/___/___, ___/___/___
Hepatitis B Vaccine

1. Series of three Hepatitis B Vaccine
   1st injection ______/______/______ 2nd Injection ______/______/______ 3rd Injection______/______/_____
   Month Day Year Month Day Year Month Day Year

   OR

2. Hepatitis B Surface Antibody titer IgG quantitative + lab copy ______/______/______/ ____________
   Month Day Year Results

3. Second series, if needed:
   1st injection _____/_____/______ 2nd Injection ______/______/______ 3rd Injection______/______/_____
   Month Day Year Month Day Year Month Day Year

Polio (circle OPV or IPV) please indicate

1. Primary series completed ______/______/______
   Month Day Year

   OR

2. Series of three Polio Vaccine
   1st injection _____/_____/______ 2nd Injection ______/______/______ 3rd Injection______/______/_____
   Month Day Year Month Day Year Month Day Year

Meningitis: (circle Menactra or Menomune) please indicate, Desired Immunization _____/______/______
   Month Day Year

(See attached sheet of lab orders to clarify questions.)

**Must be verified by Physician, PA, or CRNP**

Name: __________________________________________________________________________________________

Clinic (if applicable): __________________________________________________________________________

Address: _______________________________________________________________________________________
   City __________ State __________ Zip __________

Phone: __________________________ Fax: __________________________

Signature: __________________________ Date: __________________________

Note: Students are advised to keep a photocopy of this form for future use.