APPLICATION PACKET

Welcome

Thank you for your interest in the Practical Nursing Program at the Illinois College of Nursing (ICON). At ICON, we are committed to advancing the nursing profession by offering high standard educational courses. Attached, you will find a self-directed application packet. Enrollment is on a rolling basis but acceptance into the program is dependent upon completion of application packet, qualifications of applicant and first-come first serve basis. To ensure the quality of education each student receives, we limit the number of students we can accept each term. Please review and return the materials in its entirety to be considered into the program. Only completed applications will be reviewed and considered.

Because we value each potential student, you will be notified personally by phone in regard to the Colleges admission decision for you. The phone call will also be followed with a letter mailed to your home within five business days.

For any questions regarding the program and application process, feel free to call (630) 495-7968. We are pleased you have chosen nursing as a profession and look forward to hearing from you soon.

Best Wishes,

Illinois College of Nursing

Application Checklist

- ☐ Completed Application form
- ☐ $75 application fee (non-refundable)
- ☐ Official transcripts or GED Scores from approved schools showing evidence of successful completion of required prerequisites
- ☐ CNA Certification
- ☐ Two letters of recommendation
- ☐ Completed medical clearance form
- ☐ Completed Immunization/Serology Record form
- ☐ 10 panel drug screening from www.castlebranch.com
- ☐ Background check from www.castlebranch.com
- ☐ Proof of CPR/BLS
- ☐ Proof of Medical Insurance
- ☐ Copy of state ID, Driver's License or Resident Alien card

Submission Options:

Mail It In:
651 S Sutton Rd
#275
Streamwood, IL 60107

Upload to Dropbox:
https://www.dropbox.com/request/Z8yF6Q2hMOmrI7HGsKSs

Please upload a Folder with your documents Labeled ICON Application followed by your name.
Example: ICON_Application_LastName_FirstName

All Transcripts and Letters of Recommendation need to be mailed to us directly or submitted in a sealed envelope. Electronic transcripts are accepted if coming via an electronic transcript service.

Upon receipt of completed application packet, ICoN Office of Admissions will contact you to:

1. Schedule entrance exam- Test of Essential Academic Skills (TEAS)
    a. Basic Math, English, Science & Reading are covered

Upon acceptance into the program, students will:

1. Review and sign the Enrollment Agreement with $1,000 deposit to reserve seat
2. Review and sign the Payment Plan (if applicable)

Practical Nursing Application

Please complete all information. Please Type or print clearly using black ink only.

Contact Information:

School Year Applying For _____

Social Security Number ____ - ____ - ____ **Date of Birth** _____

Name _____
Last First Middle Maiden

Address _____
Street Apt/Suite City State Zip

Phone (____) _____ **Alternate Phone** (____) _____

Email _____

Emergency Contact

Name: _____
Last First Relationship to Student

Address _____
Street Apt/Suite City State Zip

Phone (____) _____ **Alternate Phone** (____) _____

Email _____

Academic History

High School

High Schools(s) _____

Graduation Date (Month/Year) _____ **Cumulative GPA** _____

GED

Test Date (Month/Year) _____ **GED Test Score** _____

Please include a copy of either your high school transcripts or GED scores. An official transcript will be required to be considered for program acceptance.

ACT

Scores: ____ ____ ____ Date Taken: _____
English Math Reading

Post-Secondary Education

College	State	Dates Attended	Degree(s) Earned
College	State	Dates Attended	Degree(s) Earned
College	State	Dates Attended	Degree(s) Earned
College	State	Dates Attended	Degree(s) Earned

Please include a copy of unofficial transcripts from all colleges attended. An official transcript will be required to be considered for program acceptance.

Essay Questions

Please use a separate sheet of paper to answer the following three essay questions. Responses to essay questions must be numbered and typed and must not be longer than 500 words total for all three questions.

1. Describe your personal characteristics and life experiences you feel will contribute to your success as a student and as a nurse.

2. Describe your short and long term professional goals

3. Describe your strengths and weaknesses

Medical Clearance

Student Name _____ Date of Birth _____

The student above is applying for the practical nursing program. The student will be directly caring for patients and must be able to, at minimum:

- Lift and carry 30 pounds of weight
- Lift and transfer patients to and from wheelchairs, stretchers, beds and imaging tables
- Move, adjust, and manipulate equipment
- Reposition patients
- Stand, walk, bend, lift, reach, twist and pull frequent and possibly for long periods of time
- Utilize eyesight to observe patients and manipulate equipment
- Effectively hear to communicate with patients and health care team
- Have sufficient verbal and written skills to effectively communicate
- Have sufficient fine and gross motor skills to manipulate medical equipment
- Show evidence of appropriate intellectual and emotional skills for independent judgment and discretion

Is there any evidence that you may feel will restrict you from practicing these behaviors in a safe manner?

☐ No

☐ Yes, please give Detail _____

_____

History

To be completed by applicant

Medical History

_____

_____

_____

_____

Surgical History

_____

_____

_____

_____

Family History

_____

_____

_____

_____

Physical

To be completed by healthcare provider

Medical

	Normal	Abnormal Findings
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Skin		
Neck		
Pulses		

Musculoskeletal

	Normal	Abnormal Findings
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Other Comments:

_____

_____

_____

Clearance

☐ Cleared

☐ Not Cleared

☐ Cleared with limitations (please explain) _____

_____

_____ _____

Signature of Provider (MD, DO, or NP) Date

Immunization/Serology Records

(Please Print Clearly)

Student Name: _____ **Date of Birth:** _____

1. Hep. B Surf AB

Titer date: _____ **Must provide copy of lab report**

Result:

☐ Positive

☐ Negative – start Hepatitis B Series: Dates: 1st _____ 2nd _____ 3rd _____

☐ Inconclusive-give 1 booster Date: _____ ***Repeat titer 30 days after booster***

Titer Date: _____ **Must provide a copy of lab report**

☐ Hep B Carrier *See note below for additional testing*

Note: Known Hepatitis B carriers require additional blood tests

☐ Hep B Surf Ag, Hep B core Ab and Hep Be Ag **(Again, must provide lab reports)**

2. Measles (Rubeola)

Titer date: _____ **Must provide copy of lab report**

Result:

☐ Positive

☐ Negative – give 2 boosters 30 days apart 1st _____ 2nd _____

Repeat titer 30 days after 2nd booster

☐ Inconclusive-give 1 booster Date: _____ ***Repeat titer 30 days after booster***

Titer Date: _____ **Must provide a copy of lab report**

3. Mumps

Titer date: _____ **Must provide copy of lab report**

Result:

☐ Positive

☐ Negative – give 2 boosters 30 days apart 1st _____ 2nd _____

Repeat titer 30 days after 2nd booster

☐ Inconclusive-give 1 booster Date: _____ ***Repeat titer 30 days after booster***

Titer Date _____ **Must provide a copy of lab report**

4. TB Screening/Chest X-ray

TB test must be **placed 2 months** or less from your official school start date, no exceptions
NOTE: Student with previous history of a positive tuberculin skin test **must submit a current radiology report of a chest-x-ray** taken **3 months or less** from your official school start date. BCG alone is not acceptable as a positive history unless a skin test had been given and the result was 10mm or greater

Date Placed: _____ Date Read: _____

Millimeters of Induration: _____

Chest X-ray Date: _____ **Must provide a copy of lab report**

5. Rubella

Titer date: _____ **Must provide copy of lab report**

Result:

☐ Positive

☐ Negative – give 2 boosters 30 days apart 1st _____ 2nd _____
Repeat titer 30 days after 2nd booster

☐ Inconclusive-give 1 booster Date: _____ ***Repeat titer 30 days after booster***

Titer Date: _____ **Must provide copy of lab report**

6. Tetanus/Diphtheria Booster:

Must be places **5 years or less** from your official school start date.

Booster Date: _____

7. Varicella

Result:

☐ Positive

☐ Negative – give 2 boosters 30 days apart 1st _____ 2nd _____
Repeat titer 30 days after 2nd booster

☐ Inconclusive-give 1 booster Date: _____ ***Repeat titer 30 days after booster***

Titer Date: _____ **Must provide copy of lab report**

8. COVID-19 *Must provide a copy of your vaccination card*

Date of 1st Dose: _____ Manufacturer**:** _____

Date of 2nd Dose _____ Manufacturer**:** _____

Date of Booster (if applicable): _____ Manufacturer: _____

Date of Booster (if applicable): _____ Manufacturer: _____

_____ _____

Signature of Provider (MD, DO, or NP) Date

Additional Information

What academic year are you applying for?

What is your preference for class times? ☐ Morning ☐ Evening ☐ Weekend

What is your shirt size? ☐ S ☐ M ☐ L ☐ XL

How did you hear about us? _____

How will you be paying for your education? ☐ Loans ☐ Scholarships

What are the main reasons that you will be considering our school? _____

_____