APPLICATION PACKET

ILLINOIS COLLEGE
OF NURSING

Thank you for your interest in the Practical Nursing Program at the Illinois College of Nursing (ICN). At ICN, 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 dependant 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 regards 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

Illinois College of Nursing Practical Nursing Application

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

School Year Applying For_____

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

Name _____
Last First Middle Maiden

Address_____
Street City State Zip code

Home Phone (_____) _____ **Alternate Phone** (_____) _____

Email _____

High School(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 upon acceptance into the program.

Post-Secondary Education

College	State	Dates Attended	Degree(s) Earned

*Please include an unofficial copy of transcripts from all colleges attended. An official transcript will be required upon acceptance into the program.

ACT Scores: _____ _____ _____ Date taken: _____
English Math Reading

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.

Illinois College of Nursing Letter of Recommendation

Applicant Name_____

Program applying for_____

APPLICANT: Fill the top portion of this form and submit to recommender for completion. NOTE: letter of recommendation may not be from friend or family. At least one reference should be from an instructor and/or employer. Have referencer return completed form back to you in sealed envelope with their signature across back of seal.

In accordance with the Family Education Rights and Privacy Act of 1974, you may waive your right to inspect this recommendation by signing the statement below. Should you decide not to waive the right, you will have access to the recommendation.

_____I hereby waive my right of access to this recommendation letter

_____ _____

Applicant's Signature Date

REFERENCER: Please answer questions below on a separate piece of paper and return to applicant in a sealed envelope. Please place signature across seal of envelope on back or letter will not be accepted.

1. How long have you known the applicant and in what context?

Please provide as much detail as possible for the following statements:

2. The student's overall physical and motivational ability to achieve success in the practical nursing program.

3. Specific educational and/or work experience that the student has accomplished which might predict success in the practical nursing program.

4. Comments related to character, integrity and personality of the applicant that suggest that this student will be expected to achieve a successful professional career in this field.

Recommender's signature_____ Date_____

Name _____Title_____

Institution_____

Address_____ Telephone_____

Email address_____

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Recommender's signature_____ Date_____

Name _____Title_____

Institution_____

Address_____ Telephone_____

Email address_____

Illinois College of Nursing Medical Clearance Form

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)

Temperature_____ Pulse_____ Respirations_____ B/P_____

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

MUSCULOSKELETAL		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Other Comments:

_____ Cleared
_____ Not Cleared
_____ Cleared with limitations (please explain):
_____

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

Immunization/Serology Records

(Please Print Clearly)

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

1. Hep. B Surf Ab

Titer date: _____*__Must provide copy of lab report__

Result:

Positive

Negative-start Hepatitis B series: #1date_____#2_____#3_____

Inconclusive- give 1 booster Date: _____ *repeat titer 30 days after booster 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 B e 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 Date #1:_____Date #2:_____ * repeat titer 30 days after 2nd booster

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

3. Mumps

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

Result:

Positive

Negative-give 2 boosters 30 days apart Date #1:_____Date #2:_____

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

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 a previous history of a positive tuberculin skin test **must submit a current radiology report of a chest-x-ray** taken **three** months or less from your official school start date. BCG alone is not acceptable as a positive history unless a skin test has been given and the result was 10mm or greater.

Date Placed: _____ Date Read: _____

Millimeters of Induration: _____

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

5. Rubella

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

Result:

Positive

Negative-give 2 boosters 30 days apart Date #1:_____Date #2:_____ * 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 placed **five years or less** from your official school start date. Booster date: _____

7. Varicella

Result:

Positive

Negative-give 2 boosters 30 days apart Date #1:_____ Date #2:_____ * repeat titer 30 days after 2nd booster

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

_____ _____

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

Additional information so we can serve you better:

What academic year are you applying for? _____

What is your preference for class timings? _____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 over others?

_____

_____