



Practical Nursing Program Rockbridge Area



**Application Packet
2011—2012**

Dabney S. Lancaster Community College
Practical Nursing Program
Application Packet
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Institutional Policy for Equal Opportunity

It is the policy of Dabney S. Lancaster Community College to promote equal opportunity in educational programs and activities, admission and employment without regard to race, creed, gender, national origin, disability or any other non-merit factor. For more information, contact the office of the Vice President for Instruction, Student Services and Research at 540-863-2850.

Admissions Checklist

	<u>Deadline</u>	<u>Cost</u>
Prospective Students complete the following steps:		
<input type="checkbox"/> Complete an Application for Admission to Dabney S. Lancaster Community College (on line preferred; paper enclosed.)	ASAP	No Cost
<input type="checkbox"/> Have official transcripts sent from high school(s) or other colleges you have attended.	ASAP	Varies by institution
<input type="checkbox"/> Complete an application for the Practical Nursing Program. (enclosed)	ASAP	No Cost
<input type="checkbox"/> File Free Application for Federal Student Aid (www.fafsa.ed.gov .)	ASAP	No Cost
<input type="checkbox"/> Take the required pre-admission examination and score above 50 th percentile.	TBA	\$40.00
<input type="checkbox"/> Undergo criminal background check.	ASAP	\$35.00
<input type="checkbox"/> Have three (3) references send letters directly to the Practical Nursing Program (form enclosed)	ASAP	No Cost
<input type="checkbox"/> Wait to be contacted for personal interview with the Director.		
<input type="checkbox"/> Receive letter of contingent admission or denial into the program.		

Students with Conditional Acceptance:

<input type="checkbox"/> Arrange for health assessment screening.	ASAP	Varies
<input type="checkbox"/> Take urine drug screening test.	ASAP	\$40.00

Students with Final Acceptance complete the following steps before program begins:

<input type="checkbox"/> Return Statement of Intent to enroll in the program. (enclosed)	ASAP	No Cost
<input type="checkbox"/> Register for classes at DSLCC (main campus or Rockbridge Regional Center.) Pay or secure financial aid.		Varies by semester
<input type="checkbox"/> Purchase textbooks and other selected items at DSLCC Rockbridge Regional Center in Buena Vista.		Varies by semester

NOTE: All applications and supporting documents should be mailed directly to:
 Dr. Penny Fauber, Director
 Practical Nursing Program
 Carilion Stonewall Jackson Hospital
 One Health Circle
 Lexington, VA 24450

“Please note that costs for items such as supplies, equipment, uniforms, etc. are provided for the convenience of students who may wish to develop a budget for program-related expenses. The figures are only estimates and are subject to change without notice. DSLCC is not responsible for any increases in the figures listed.”



**Application for Admission
Practical Nursing Program**

Date of Application _____

Name _____
Last First Middle/Maiden

Current Address _____
Street

_____ City State Zip

Phone Number _____
Home Cell Work

Email _____

How long have you lived at current address? _____

If living at current address for less than two years, list other address

_____ From (mo/yr) To (mo/yr) Address City State

Birth Date _____ Social Security Number _____

References: Only professional persons or previous employers are to be used. No family members or personal friends. If you have previously been enrolled in a nursing program, one of the references *must be from a former nursing instructor*. **Please ask each reference to send a letter directly to the Practical Nursing Program Director.**

Name Complete Address and Phone # Occupation

Have you ever applied to this nursing school before? Yes ____ No ____

If yes, when? _____

Reason for not attending? _____

Do you have any experience in nursing? Yes _____ No ____

If yes, what experience do you have? _____

The following information is required by the laws of the Commonwealth of Virginia.

Have you ever been convicted, pled guilty to, or pled no contest to the violation of any federal, state, or local law which constituted a felony or misdemeanor, excluding traffic violations, but including driving while intoxicated?

Yes ____ No ____

Have you ever had action taken against you or been denied a certification of a license in a health-related field?

Yes ____ No ____

Explain any yes answers below:

Please note: A criminal background check will be done on each applicant by the Department of Social Services and the Virginia State Board of Nursing.

Education

Type	Name of School	City	State	From	To	Graduate? _____
------	----------------	------	-------	------	----	-----------------

High School	_____					
-------------	-------	--	--	--	--	--

Trade/Vocational	_____					
------------------	-------	--	--	--	--	--

GED	_____					
-----	-------	--	--	--	--	--

College	_____					
---------	-------	--	--	--	--	--

Nursing	_____					
---------	-------	--	--	--	--	--

Employment Experience (begin with most recent) attach extra sheet if needed

From	To	Employer	Position	Reason for Leaving
------	----	----------	----------	--------------------

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

In your own words briefly state why you are interested in nursing and why you feel you should be admitted to this program.

Do you plan to apply for financial aid? Yes _____ No _____

I hereby certify that the statements made in the application are true to the best of my knowledge. I understand that falsifying any statements may lead to non-acceptance or dismissal from the program.

_____	_____
-------	-------

Signature of Applicant

Date

Printed name

For Office Use Only	
Empl. ID _____	
IS _____ OS _____	
Staff Initial _____	
Date _____	



APPLICATION FOR ADMISSION

Please Note: In compliance with the Sex Offender and Crimes Against Minors Registry, a portion of this information will be submitted to the Virginia State Police.

1. Name: _____

First
Full Middle
Last
2. Social Security Number: _____ - _____ - _____
See privacy statement, which can be obtained in the Admissions Office.
3. Former name: _____

First
Full Middle
Last
4. Date of birth: _____ / _____ / _____

(Month)
(Day)
(Year)
5. Have you previously attended, applied for admission to, or been employed by any Virginia Community College?
 Yes No **If yes, SIS ID (Empl ID), if known:** _____
6. In what type of class will you be enrolling? Credit classes Non-credit/CEU classes
7. What college do you plan to attend? _____ (if applicable)
8. Prefix: Mr. Miss Ms. Mrs. Dr.
9. Suffix: Jr. Sr. II III IV V Esq. Ph.D. DVM
10. What term will you begin classes?: 20____ Term: _____ Fall (Aug-Dec) Spring (Jan-May) Summer (May-Aug)
11. Phone (include area code): (_____) _____ - _____
12. Mailing address: _____

(Street)
(City)
(State)
(ZIP)
(Country, if not USA)
13. County, City, State or Country of Residence: _____
Provide what you consider to be your location of residence. If you temporarily relocated to your current address to get an education, you should provide your previous location.
14. Email address: _____
This address will be your unofficial e-mail address; you will be assigned an official e-mail address after your application has been entered in the Student Information System.
15. Business phone (if employed): (____) _____ - _____ extension: _____
16. Employer (if employed): _____
17. Gender: Male Female
18. Is English your native language? Yes No
19. **U.S. Citizen Status:** Native Naturalized Alien Permanent Alien Temporary Not reported or Not living in the U.S.

Note: If you have been a U.S. Citizen since birth, choose Native. If you became a U.S. Citizen after birth, choose Naturalized. If you are not a U.S. Citizen, choose one of the types of alien statuses based on your visa. "Alien Permanent", "Alien Temporary" or "Not reported or Not living in the US" applicants must complete the remainder of the question on Citizen Status.

Country of Citizenship? _____ **Permanent Status:** Resident Alien Asylee Refugee A#: _____

Visa Type: _____ Visa Expiration Date: _____

(Month)
(Day)
(Year)

If you chose "Not reported or Not living in the US," what Visa Status are you requesting? _____

20. Ethnic group: ___ White ___ Black/African American ___ Hispanic/Latino ___ Asian ___ American Indian/Alaska Native ___ Native Hawaiian/Other Pacific Islander

21. Military information: ___ No Military Service ___ Spouse ___ Dependent ___ Active duty ___ Active reserves ___ Inactive reserves ___ Retired ___ Veteran/VA Ineligible ___ Veteran Branch: _____

Please complete the rest of this form if you plan to pursue a credit program of study or credit classes. If you selected "non-credit", please sign and date the application. If you wish to be considered for in-state tuition rates, certain contract rates, or are planning to apply for Senior Citizen benefits, you must also complete the Application for In-State Tuition.

22. Secondary Education Type: ___ High School ___ GED Program ___ Home Schooling

Secondary Education: School or Agency Name: _____

Located in: _____

City/County State Country

GED or High School Graduation Date: _____ Anticipated Graduation Date: _____
mm/yy mm/yy

Non-Graduate: Highest grade completed: _____ Date completed: _____
mm/yy

Type of high school diploma or certificate: ___ General ___ Other ___ Don't Know

Please use the following types of diplomas or certificates: General Diploma (Includes: Advanced Studies, Standard, Modified Standard, or GED), Other (Includes: Special Diploma or Certificate of Completion), or Don't Know

23. Do you plan to pursue a degree, certificate, or diploma? ___ Yes ___ No

If yes, then identify your plan of study (refer to the college's list of plans): _____

(Financial Aid students must check yes and enroll in an approved plan of study). (Include specialization/sub-plan, if applicable).

If No, give reason for taking classes: **(Check only one)**

___ Upgrading current job skills ___ Developing skills for new job ___ Exploring career options

___ Pursuing personal interest or general knowledge ___ Currently pursuing degree at another college (transient/visitor)

___ Planning to pursue a degree at another college (non-degree/transfer)

High School Applicants Only: ___ Dual Enrollment ___ Principal Permission ___ Dual Enrollment/Principal Permission

24. Colleges/Universities attended. If you have taken any college classes, please list all colleges attended with most recent first. Indicate any degrees earned in the last column with an **A** for Associate, **B** for Bachelor's, **M** for Master's, **D** for Doctorate or **P** for Professional Degree. If you have not earned a degree, leave the Degrees column blank.

College or University	City, State/Country (if not USA)	Dates Enrolled	Degrees
		-	
		-	
		-	
		-	

25. Are you eligible to enroll at the last college attended? ___ Yes ___ No

26. What campus do you plan to attend? _____ (If College has more than one campus, indicate the campus you plan to attend).

27. Do you want to apply for in-state tuition rates? ___ Yes ___ No

Selecting NO will cause you to be charged higher out-of-state tuition rates.

Eligibility for in-state tuition is pursuant to Section 23-7.4, Code of Virginia.

Please contact the college admissions office if you have any questions.

I certify under penalty of disciplinary action that all of the information is complete and accurate. I agree to supply the college with supporting documentation related to my application, if I am requested to do so.

Applicant's Signature: _____ **Date:** _____

Parent/Legal Guardian's Signature: _____ **Date:** _____

(If under 18 years of age)

This institution promotes and maintains educational opportunities without regard to race, color, sex, ethnicity, religion, gender, age (except when age is a bona fide occupational qualification), disability, national origin or other non-merit factors. Employer, date of birth, sex, and race information are used for research, reporting and management of student records.

Application for In-state Tuition

Eligibility for in-state tuition is pursuant to Section 23-7.4, Code of Virginia.

Please contact the college admissions office if you have any questions.

1. Applicant's Name: _____ Date of birth: ____/____/____
(First) (Full Middle) (Last) (mm) (dd) (yy)

Applicant's Social Security Number: _____

2. Please choose the domicile on which you want to base your eligibility for in-state tuition:

- Parent's Domicile:** Choose this option if you receive over half of your financial support or you are claimed as a tax dependent by your parents.
- Legal Guardian's Domicile:** Choose this option if you are under the custody of a court-appointed legal guardian.
- Spouse's Domicile:** Choose this option if you are married and want to claim eligibility for in-state tuition based on your spouse's domicile.
- Your Domicile:** Choose this option if you want to claim eligibility for in-state tuition based on your own domicile.

If you are under the age of 24, your eligibility must be based on your parent or legal guardian unless one of the following applies:
(Check all that apply.) You may be required to supply "clear and convincing evidence" of your status.

- I am a veteran or active duty member of the U.S. Armed Forces.
- I have legal dependents other than my spouse.
- I am a ward of the court or was a ward of the court until age 18.
- I am enrolled in graduate school.
- I am married.
- Both of my parents are deceased and I have no adoptive or legal guardian.
- I can present clear and convincing evidence that I am financially self-sufficient.

3. Provide the name of the person upon whom you are basing your domicile: _____
(First) (Middle) (Last)

4. Answer the following questions. For the entire 12 months prior to the term in which you enroll, will the person listed above:

- ... continuously lived in and continue to live in Virginia? Yes No
- ... filed a tax return or paid income taxes to Virginia? Yes No Income Income in another state
- ... been a United States citizen? Yes No
- ... **If "No"**, been a permanent alien resident? Yes No **If "Yes"**, provide the A#: _____
- ... been registered to vote in Virginia? Yes Not Registered to Vote Registered in another state
- ... held a valid Virginia driver's license or Virginia DMV ID? Yes No license or ID Licensed in another state
- ... owned or operated a motor vehicle registered in Virginia? Yes No Vehicle Registered in another state
- ... **lived outside of Virginia**, but worked in Virginia, earned at least the equivalent of a full-time wage salary, and paid Virginia income taxes on all taxable income in this Commonwealth? Yes No
- ... filed a tax return or paid income taxes to a state other than Virginia? Yes No **If yes**, paid or filed in what state? _____

5. Is the person listed above on active duty with the military? Yes No

If yes, provide the state listed on the Leave and Earnings Statement (LES) and the date when it became effective for this state:

State: _____ Effective Date: _____ (mm/dd/yy)

Is the person listed above stationed in Virginia pursuant to orders? Yes No

If yes, provide the reporting date listed on the orders to Virginia. _____ (mm/dd/yy)

If yes, will the spouse of the person listed above have resided in Virginia, earned at least the equivalent of a full-time wage salary and paid income taxes to Virginia for one year prior to the start of the term in which you will enroll? Yes No

6. Has the person listed above retired or been discharged from the military? Yes No

If yes, provide the retirement or discharge date. _____ (mm/dd/yy)

7. Is the spouse of the person listed above on active duty with the military? Yes No

If yes, provide the state listed on the Leave and Earnings Statement (LES) and the date when it became effective for this state:

State: _____ Effective Date: _____ (mm/dd/yy)

Is the spouse of the person listed above stationed in Virginia pursuant to orders? Yes No

If yes, provide the reporting date listed on the orders to Virginia. _____ (mm/dd/yy)

If yes, will the person listed above have resided in Virginia, earned at least the equivalent of a full-time wage salary and paid income taxes to Virginia for one year prior to the start of the term in which you will enroll? Yes No

8. Has the spouse of the person listed above retired or been discharged from the military? Yes No

If yes, provide the retirement or discharge date. _____ (mm/dd/yy)

Please note: If you knowingly provide erroneous information to evade payment of out-of-state tuition and fees, you will be charged out-of-state tuition and fees for each term attended and may be subject to dismissal. Random audits of this information will be performed. I certify under penalty of disciplinary action that all of the information is complete and accurate. I agree to supply the college with supporting documentation related to my application, if I am requested to do so.

Signature of Applicant

Date

Signature of Parent, Legal Guardian or Spouse

Date



Dear Applicant:

Thank you for your interest in the Practical Nursing Program.

The deadline for submission of application materials and paying for the pre-admission examination is March 1, 2011. The required pre-entrance examination will be administered on March 14, 2011 in the Ground Floor Conference Room of Carilion Stonewall Jackson Hospital. It is best to return your completed application as soon as possible. You then have until the deadline to submit your other application materials and pay for the examination.

Applications received after the deadline will not be considered. Applicants will not be admitted into the examination session unless proof of payment is shown.

If you have any questions regarding the application process please call me at 540-458-3299. The email address is pfauber@dslcc.edu.

Sincerely,

Penny Fauber, PhD, RN
Director



Dear Applicant:

The required pre-admission examination for admission to the Practical Nursing Program will be held in the Ground Floor Conference Room of Carilion Stonewall Jackson Hospital, One Health Circle, Lexington, Virginia. The date is March 14, 2011.

Only one examination is given each year, so it is mandatory that you be present on this date if you wish to be considered for July admission.

Registration will be held between 8:15 am and 8:45 am. The exam will begin promptly at 9:00 am. No one will be admitted to the room after the exam begins.

The exam takes approximately four (4) hours to complete and includes one 20-minute break. The exam fee is \$40.00 and is non-refundable. You may pay with cash, personal check, credit card, money order, or cashier's check. Checks and money orders should be made out to DSLCC. ***Deadline for payment is March 1, 2011. Payment should be made at the DSLCC Rockbridge Regional Center in Buena Vista. Please bring your receipt for payment on the day of testing.***

On the day of the exam, you will need to bring a picture ID (driver's license), the required fee, and several sharpened #2 pencils and your receipt for payment of the test. You may not use books, notes, or calculators during the exam.

Prior to taking the exam, your completed application, transcript, and references must be on file with the nursing program director. Deadline for these items is March 1, 2011.

There will be no exceptions to these requirements. In the case of inclement weather, natural disaster or other emergency, please listen to the local radio station for announcements regarding cancellation of the exam.

If you have any questions, please call the Nursing Program office at 540-458-3299.

Sincerely,

Penny Fauber, Ph.D., RN
DSLCC/PNP Director



Practical Nursing Program

REFERENCE (1)

Section 1 (to be completed by applicant)

The following information must correspond to the information submitted on your practical nursing program application. Give this form to your reference along with an envelope addressed to ***Dabney S. Lancaster Community College, Practical Nursing Program, Carilion Stonewall Jackson Hospital, One Health Circle, Lexington, VA 24450.*** The reference form must be sent from the person completing the reference and returned directly to the director.

Last Name	First Name	Middle/Maiden Name
-----------	------------	--------------------

Name of Reference _____

The Family Education Rights and Privacy Act of 1974 guarantees students' access to their educational records. Students, however, are entitled to waive their rights of access concerning recommendations. The following signed statement is the applicants wish regarding this recommendation.

_____ *I waive my right to inspect the contents of this recommendation*

_____ *I do not waive my rights to inspect the contents of this recommendation.*

Section 2 (to be completed by reference person)

The Practical Nursing Program will value your comments on the suitability of this applicant to do the assigned work associated with nursing and will hold your comments in confidence if the applicant has signed the above waiver.

For how long and in what capacity have you known the applicant? _____

Please rate the following traits to the best of your ability for this applicant.

AREA	SUPERIOR	GOOD	AVERAGE	POOR	UNKNOWN
Intellectual Ability					
Ability to analyze a problem					
Self-reliance					
Leadership					
Personal grooming					
Motivation					
Self-discipline					
Ability to get along with others					
Oral communication skills					
Written communication skills					
Reliability					

RECOMMENDATION

We are very interested in obtaining an accurate profile of this applicant's ability for the practical nursing program. We realize that check-off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments.

Your overall assessment of the applicant to his/her ability to complete nursing school is:

Highly recommend Recommend with reservation Do not recommend

Signature _____ Date _____

_____ Print Name

Institution/Job _____

Your Position _____ Phone # _____



Practical Nursing Program

REFERENCE (2)

Section 1 (to be completed by applicant)

The following information must correspond to the information submitted on your practical nursing program application. Give this form to your reference along with an envelope addressed to **Dabney S. Lancaster Community College, Practical Nursing Program, Carilion Stonewall Jackson Hospital, One Health Circle, Lexington, VA 24450**. The reference form must be sent from the person completing the reference and returned directly to the director.

Last Name	First Name	Middle/Maiden Name
-----------	------------	--------------------

Name of Reference _____

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The Practical Nursing Program will value your comments on the suitability of this applicant to do the assigned work associated with nursing and will hold your comments in confidence if the applicant has signed the above waiver.

For how long and in what capacity have you known the applicant? _____

Please rate the following traits to the best of your ability for this applicant.

AREA	SUPERIOR	GOOD	AVERAGE	POOR	UNKNOWN
Intellectual Ability					
Ability to analyze a problem					
Self-reliance					
Leadership					
Personal grooming					
Motivation					
Self-discipline					
Ability to get along with others					
Oral communication skills					
Written communication skills					
Reliability					

RECOMMENDATION

We are very interested in obtaining an accurate profile of this applicant's ability for the practical nursing program. We realize that check-off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments.

Your overall assessment of the applicant to his/her ability to complete nursing school is:

___ Highly recommend ___ Recommend with reservation ___ Do not recommend

Signature _____ Date _____

_____ **Print Name** _____

Institution/Job _____

Your Position _____ Phone # _____



Practical Nursing Program

REFERENCE (3)

Section 1 (to be completed by applicant)

The following information must correspond to the information submitted on your practical nursing program application. Give this form to your reference along with an envelope addressed to ***Dabney S. Lancaster Community College, Practical Nursing Program, Carilion Stonewall Jackson Hospital, One Health Circle, Lexington, VA 24450.*** The reference form must be sent from the person completing the reference and returned directly to the director.

Last Name	First Name	Middle/Maiden Name
-----------	------------	--------------------

Name of Reference _____

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_____ *I waive my right to inspect the contents of this recommendation*

_____ *I do not waive my rights to inspect the contents of this recommendation.*

Section 2 (to be completed by reference person)

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For how long and in what capacity have you known the applicant? _____

Please rate the following traits to the best of your ability for this applicant.

AREA	SUPERIOR	GOOD	AVERAGE	POOR	UNKNOWN
Intellectual Ability					
Ability to analyze a problem					
Self-reliance					
Leadership					
Personal grooming					
Motivation					
Self-discipline					
Ability to get along with others					
Oral communication skills					
Written communication skills					
Reliability					

RECOMMENDATION

We are very interested in obtaining an accurate profile of this applicant's ability for the practical nursing program. We realize that check-off items sometimes do not provide the opportunity to characterize the applicant as fully as you would like. Please give any additional comments.

Your overall assessment of the applicant to his/her ability to complete nursing school is:

___ Highly recommend ___ Recommend with reservation ___ Do not recommend

Signature _____ Date _____

_____ Print Name

Institution/Job _____

Your Position _____ Phone # _____

Important Contact Information

DSLCC Main Campus

Julia Carter, Secretary
ADN Program
540-863-2838

Joy Broyles, Academic Advisor
ADN Program
540-863-2861

Transcripts
Lorrie Wilhelm Ferguson
Registrar
540-863-2823

Bookstore
540-863-2908

Student Services
540-863-2815

Financial Aid Office
540-863-2821

Library
540-863-2864

DSLCC Rockbridge Regional Center

35 Vista Links Drive
Buena Vista VA 24416
540-261-1211

Dr. Penny Fauber, Director
Practical Nursing Program
Carilion Stonewall Jackson Hospital
One Health Circle
Lexington, VA 24450
540-458-3299

Ms. Gloria Smitka, Faculty
Rockbridge Regional Center
35 Vista Links Drive
Buena Vista, VA 24416
540-863-2842