



St. Francis Medical Center  
**School of Nursing**

601 HAMILTON AVENUE, TRENTON, NEW JERSEY 08629-1986

**APPLICATION FOR ADMISSION**

*(Submission deadline for generic or extended program is March 31)  
(Submission deadline for LPN to RN Transition program is February 28)*

PLEASE PRINT IN INK OR TYPE

Review the application to ensure that all information is complete and accurate. Submit your completed application with all required documents to the above address. **REMEMBER TO INCLUDE THE \$50.00 NON-REFUNDABLE APPLICATION FEE, CHECK OR MONEY ORDER ONLY, PAYABLE TO: St. Francis Medical Center School of Nursing.**

TODAY'S DATE: \_\_\_\_\_ PREFERRED ENTRANCE: AUGUST, 20 \_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

PROGRAM OPTION OF INTEREST (check  one): EXTENDED RN \_\_\_\_\_ GENERIC RN \_\_\_\_\_ LPN TO RN \_\_\_\_\_  
(3-Year Program) (2-Year Program) (9-month Program)

PREFERRED TITLE (circle one): MS., MISS, MRS., MR., OTHER: \_\_\_\_\_

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

PREVIOUS LAST NAME(S) (if any): \_\_\_\_\_ PREFERRED "CALL" NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ (For Identification Purposes - Year Optional) U.S. CITIZEN:  Yes  No  
Mo Day Year If NO, provide your visa or immigration status: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
NUMBER AND STREET, INCLUDE APARTMENT NUMBER

CITY STATE ZIP CODE COUNTY

TELEPHONE: Home (\_\_\_\_) \_\_\_\_\_ Alternate Daytime/Work (\_\_\_\_) \_\_\_\_\_

E-MAIL (Indicate proper case): \_\_\_\_\_

**PERSON TO BE NOTIFIED IN CASE OF EMERGENCY DURING NORMAL SCHOOL HOURS:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**GENERAL BACKGROUND:** (Answer ALL of the following questions)

Have you previously applied for admission to this School?  Yes  No If yes, when? \_\_\_\_\_

Have you completed a Chemistry course with a minimum "C" grade, that is less than ten years old?  Yes  No If yes, in  high school  college

Have you ever been convicted of a felony?  Yes  No If yes, attach explanation.

Have you ever been a habitual user of drugs?  Yes  No If yes, attach explanation.

Are you currently licensed as an LPN?  Yes  No If yes, in what state? \_\_\_\_\_

Are you related to a St. Francis SON alumnus?  Yes  No If yes, name and relationship: \_\_\_\_\_

Are you related to a St. Francis employee?  Yes  No If yes, name, department, relationship: \_\_\_\_\_


What do you consider your current occupation? (Use "Student" if appropriate.): \_\_\_\_\_

**OPTIONAL INFORMATION:** (Answers to this section are requested, but not required. Your answers will NOT affect consideration of your application.)

Gender:  M  F Racial Background:  White  Black or African American  Asian  American Indian or Alaska Native  
 Native Hawaiian or other Pacific Islander

Marital Status: \_\_\_\_\_ Ethnic Background:  Hispanic or Latino  Not Hispanic or Latino



 **APPLICATION ESSAY:** In the space below write a concise essay detailing the factors you consider important in your decision to become a Professional Nurse. It will be helpful if you include the following: your activities in recent years; your reasons for selecting a nursing career; any special reasons for your interest in attending this School; the contributions you feel you will make to nursing; any specific career goals you have at this time. **Please try to confine your essay to the space provided.**

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**PROFESSIONAL REFERENCES** (*Teacher/professor, employer/supervisor, or community service representative*), family and friends are not valid references. List below the individuals to whom you have given Admissions Reference forms. Each form should be returned to you in a sealed envelope to be mailed with your application.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

I understand that I may be denied licensure, or permission to sit for a licensing examination, by the State Board of Nursing if I have been convicted of a felony.

By my signature below I certify that all information provided on this application, and any attachments thereto, is true, complete and accurate to the best of my knowledge. I understand that falsification or omission of any requested information is sufficient grounds for rejection of my application or dismissal from the School as a student. I agree that all information provided to the School may be used by the School for any purpose including, but not limited to, making an admissions decision. **I have enclosed my *Non-Refundable* Application Fee of \$50.00.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

*St. Francis Medical Center School of Nursing admits students of any age, race, color, gender, religion, national or ethnic origin, marital status, sexual orientation, or disability to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of age, race, color, gender, religion, national or ethnic origin, marital status, sexual orientation, or disability in the administration of its educational policies, admissions policies, scholarship or loan programs, or other school administered programs.*