WASHINGTON SCHOOL OF PRACTICAL NURSING
FOUR RIVERS CAREER CENTER

School District of Washington
1978 Image Drive
Washington, MO 63090
Phone 636-231-2141
E-Mail: chris.redd@sdowmo.org

APPLICATION FOR ADMISSION
2024-2025

Please print or type and fill in **ALL** blanks Today's Date:_____

PERSONAL DATA

Name_____
Last First Middle Maiden

Address_____ Phone Number_____
Street, P.O. Box, Route

_____ Email_____
City, State, and Zip Code

County_____ Date of Birth_____

High School Diploma_____ Name of School_____
Date Received

Address of High School_____

GED_____ Certificate Number_____ State_____

Have you ever attended a School of Nursing? Yes____ No_____

If yes, Name of school_____

Address of school_____

Date Entered_____ Date Terminated_____

Reason for leaving_____

Have you ever attended a college, university, or technical school? Yes____ No_____

If yes, name, address, and dates attended (use additional sheet if needed) _____

_____

_____

While attending another school, did you receive financial assistance? Yes____ No_____

RELEASE OF INFORMATION IN REFERENCE TO STUDENT AND OTHER AGENCIES

Four Rivers Career Center's official policy on release of information about students is in accordance with the *Family Educational and Privacy Act of 1974.* In general, this legislation provides that a student 18 years or older or the parents of a student under 18 years of age are to be granted access to the student's school records.

Information that includes the student's name, address, telephone listing, dates of attendance, grades, and the most recent and/or previous educational agency or institution attended by the student may be released without consent of the student. Other records may not be released without permission.

I give permission for any institutions that I have previously attended to release information to FRCC, when needed in regards to my school record.

*Signature*_____ *Date*_____

I hereby give my permission to FRCC to release my student records to employers, or potential employers, and/or other educational institutions that request these records.

*Signature*_____ *Date*_____

Students may request in writing on a semester basis that release of any or all directory information be withheld. Students should consider very carefully the consequences of any decision to withhold any category of directory information.

Student records are defined as any and all "official records." A student has the right to inspect his or her academic record and is entitled to an explanation of information that has been recorded. Documents submitted by or for the student in support of his or her application for admission or for transfer credit will not be returned to the student, or sent elsewhere. A request for transcript of other academic information from another institution of learning may be released only with written consent of the student.

Programs at Four Rivers Career Center are committed to a policy of equal education opportunity. All educational programs are administered with regard to sex, handicap, race, color, age, or national origin. This includes all activities and employments as required by *Title IX, Section 504. Title VI.*

Contact person:
Title VI, Section 504 Coordinator
School District of Washington
220 Locust Street, Washington, Missouri 63090

WASHINGTON SCHOOL DISTRICT BUILDINGS AND GROUNDS ARE ESTABLISHED AS A SMOKE FREE ENVIRONMENT.

REFERENCES

Work Experience: (Begin with **current/most** recent employer)

Name of employer_________________________________ Date of Employment___________to____________

Address____
Street P.O. Box Route City State Zip

Supervisor ____Email ____
Name

Position Held______________________________________ Reason for Leaving _________________________________

Name of employer_________________________________ Date of Employment ___________to____________

Address ____
Street P.O. Box Route City State Zip

Supervisor ____Email ____
Name

Position Held _____________________________________ Reason for Leaving_________________________________

Name of employer_________________________________ Date of Employment ___________to____________

Address____
Street P.O. Box Route City State Zip

Supervisor ____Email ____
Name

Position Held _____________________________________ Reason for Leaving_________________________________

*You may list additional employers on a sheet of paper.

Personal--Excluding family members

Name_______________________________________Email ___________________________ Phone Number _________________

Address____
Street P.O. Box, Route City State Zip

How long have you known this person?__________________ What capacity?_____________________________________

Name_______________________________________Email ___________________________ Phone Number _________________

Address____
Street P.O. Box, Route City State Zip

How long have you known this person?__________________ What capacity?_____________________________________

Name_______________________________________Email ___________________________ Phone Number _________________

Address____
Street P.O. Box, Route City State Zip

How long have you known this person?__________________ What capacity?_____________________________________

***We will be contacting references as desired.**

GENERAL INFORMATION

How did you hear about this program?_____

TO ENSURE COMPLIANCE WITH THE NURSING PRACTICE ACT, SECTION 335.011 THROUGH 335.096, ANSWER THE FOLLOWING QUESTIONS:

Have you ever been convicted, adjudged guilty by a court, plead guilty, or nolo contendere to any crime, (excluding traffic violations)?

Yes____ No_____ If yes, explain_____

Have you ever been convicted, adjudged guilty by a court, plead nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol?

Yes____ No_____ If yes, explain_____

All students must comply with the Missouri Nurse Practice Act sections 335.046, 335.066 and 335.081 and Missouri Code of State Regulations 20CSR 200-4.020(3) to sit for the NCLEX-PN Board Exam. Decision to accept or deny the application rests with the Missouri state Board of Nursing and graduation from this program does not guarantee eligibility to write the NCLEX-PN Board Exam. A copy of the Missouri Nurse Practice Act will be provided to you for your reference.

I certify that all the preceding information is true and correct to the best of my knowledge. If asked by an authorized official, I agree to give proof of the information that I have given on this form. Falsification of information may result in my dismissal.

Signed_____

Date_____