# HARMONY HEALTH CARE INSTITUTE, INC

# Licensed Practical Nurse Program Application Form

**Directions:**

- Please Type or Print using black ink.
- A Bank Check or Money Order of $350.00 made payable to *Harmony Health Care Institute*
- Your completed application must be submitted with the following documents:

  1. A $350.00 Bank Check or Money Order made payable to *Harmony Health Care Institute*
  2. Applicant's Personal Statement (Use enclosed sheet)
  3. Your Current Resume/Work History
  4. Official Documentation of U.S. High School Graduation/Equivalent
  5. Official Entrance Test Result
  6. Reference Form #1, #2, & #3 (two of the references must be professional references)
  7. Copy of State issued Identity Card/Driver's License
  8. A copy of age verification document (you must be 18 years of age or older)

- The following documents must be provided to meet the clinical requirements:
  [Failure to provide these documents may result in inability to attend clinical.]
  1. Criminal Record Release Form (Part I & II must be completed, notarized and mailed with the required fee to the NH state agency address listed on the form)
  2. Health Status Verification Forms
  3. CPR certification (Adult, Infant and Child)

Anticipated Course Start Date:_____ SSN _____

_____

Last Name First Name Middle Initial Maiden Name

_____

Mailing Address

_____ _____

City, State, Zip Code Date of Birth

(___)_____(____)_____(____)_____

Day Phone Evening Phone Work Phone

_____

Email Address (Please PRINT CLEARLY)

DEMOGRAPHIC INFORMATION (Please complete as applicable.)

U.S. Citizen □ Yes □ No Country of Origin _____

□ Male □ Female Marital Status □ Married □ Single Number of Children ____

Means of Transportation: □ Own Vehicle □ Carpooling □ Other _____

Employment Status: □ Full-Time (30-40 Hrs/Wk) □ Part-Time (Less than 30 Hrs/Wk □ Unemployed

Yearly Income: □ Less than $10,000 □ $10,000 - $15,000 □ $16,000 - $20,000 □ $21,000- $25,000
□ More than $25,000

Primary Language: □ English
□ Spanish
□ French
□ Other: Specify _____

Race: □ Caucasian/White
□ African American/Black
□ Native American
□ Hispanic
□ Asian
□ Other: Specify _____

OFFICE USE ONLY

| | |
|---|---|
| Application Fee Received: | DATE: |
| Financial Coordinator : | DATE: |
| Admission Coordinator: | DATE: |

Reviewed/Revised 11/09, 01/12, 10/12, 6/13;7/14

**EDUCATIONAL HISTORY**

| Type or Level | Name & Address of School | Dates Attended | Diploma or Degree Earned |
|---|---|---|---|
| High School or GED | | | |
| College/ University | | | |
| Other | | | |

Have you taken the Entrance Test(s) within the last (1) year?_____If yes, When? _____

Have you previously applied for admission to HHCI?_____If yes, When? _____

Do you have previous course work that you wish to transfer to HHCI? _____

If yes, has HHCI received official transcript of the coursework?_____

Do you have access to reliable transportation? □ Yes □ No

If no, have you made adequate arrangements for transportation to class and to the clinical site(s)?

_____

Do you have a learning disability or have any documented handicap? □ Yes □ No

If yes, prepare to provide supporting documentation during your admission interview.

Have you ever been convicted of a felony? □ Yes □ No (Violations do not include traffic or parking violations or convictions that have been annulled)

What are your educational and career goals? _____

_____

_____

_____

_____

Do you have healthcare-related work experience? If yes, please list which area of healthcare, company and give a brief description of your work experience.

_____

_____

_____

Please attach a statement of not more than 100 words stating why you believe you are especially prepared to benefit from this Licensed Practical Nurse Program. Your statement should include any experiences you may have had that contributed to or influenced your decision.

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## REFERRAL INFORMATION

How did you hear about Harmony Health Care Institute? (Please check many as applicable).

☐Current Student _____ ☐ Current Employee_____

☐ Faculty/ Instructor_____ ☐ Newspaper Ad_____

☐ Internet _____ ☐ Other _____

## EMERGENCY CONTACT INFORMATION

### Primary Contact Person

Name: _____

Home Phone: ( ___ ) _____Work Phone: (____ ) _____

Cell Phone: ( ____) _____ Other Phone: ( ____) _____

Relationship: _____

### Secondary Contact Person

Name: _____

Home Phone: ( ___ ) _____Work Phone: (____ ) _____

Cell Phone: ( ____) _____ Other Phone: ( ____) _____

Relationship: _____

Any information provided by the applicant on this application is treated strictly as confidential information. Please note that Harmony Health Care Institute reserves the right to deny admission to any applicant who does not meet the stipulated requirement or possess the criteria necessary for success in the program of study applied for.

In the event that I am accepted, I agree to abide by the student policies and procedures contained in the Licensed Practical Nurse Program Student Handbook. I have reviewed all the above responses and statements, and certify that the information I have provided in this application is complete and true to the best of my knowledge. I understand that any omission or misrepresentation of fact in this application may result in the denial of admission / enrollment or possible dismissal from the program at any point throughout the duration of the course. I hereby authorize Harmony Health Care Institute to verify the information provided in the application, references, previous employment, and conduct a check on my background both criminal and educational.

_____ _____

Applicant's Signature Date