HARMONY HEALTH CARE INSTITUTE, INC

Licensed Practical Nurse Program

Admission Application Form

DIRECTIONS:

- Please Type or Print using black ink.
- If your application fee is paid in a money order or bank check; please make it payable to *Harmony Health Care Institute*
- Your completed application must be submitted with the following documents in order to be deemed complete:

  1. Application fee of $350.00 in cash or money order/bank check
  2. Applicant's Personal Statement (Please type on a separate sheet using the directions on the application form)
  3. Your Current Resume/Work History
  4. Official High School/GED Transcript/Foreign Transcripts with Evaluation for US equivalency
  5. Official Entrance Testing Result – if you have tested somewhere other than HHCI
  6. References: Two (2) professional and one (1) personal on applicable reference form or written/emailed specifying type of reference, name of applicant, relationship to applicant and if professional; where you worked together
  7. Copy of current State issued Identity Card/Driver's License

- The following documents must be provided to meet the clinical requirements of the LPN program:

  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. BEAS registry consent form (filled out and returned to Admissions to complete)
  3. Health Status Verification Forms
  4. CPR certification (Adult, Infant and Child)

*[*Failure to provide the above clinical required documents or presence of prohibitive information in the CORI or BEAS report may result in a student's inability to attend clinical and/or possible dismissal from the LPN program.*]

Anticipated Course Start Date: ______________ SSN ____

____
Last Name First Name Middle Initial Maiden Name

____
Previous Names Used

____
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 ☐ Resident Alien ☐ Non-resident Alien

Place of Birth: ____
City State Country

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

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

Are you applying for financial aid? ☐ Yes ☐ No

Primary Language: ☐ English
☐ Spanish
☐ French
☐ Other: Specify _______________

Ethnicity/Race:
☐ African American/Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Caucasian/White
☐Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander
☐ Two or more Races
☐ Unknown

Application Fee Received:	**Date:**
Financial Coordinator:	**Date:**
Admission Coordinator:	**Date:**

Revision Date: 11.14.2017

EDUCATIONAL HISTORY

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

GENERAL QUESTIONS

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 previously completed course work that you wish to transfer to HHCI? _____________________

If yes, has HHCI received supporting documentation (*i.e., official transcript, course description, syllabi, etc.*) of the previously completed 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 learning or physical disability that you think may impact your ability to benefit from the LPN program? ☐ Yes ☐ No

If yes, submit a written request for accommodation (if needed) along with appropriate supporting documentation to the admissions office prior to your admission interview date (*please see the School Catalog and Consumer Disclosure Information for the school policy and procedure for disability accommodations*).

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.

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PERSONAL STATEMENT

Please attach a **typed** 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.

Make sure to identify your personal statement as such, see example of header below:

John Smith
Personal Statement
August 8, 2017

REFERRAL INFORMATION

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

☐ Current Student___________________________ ☐ HHCI Employee _____________________________

☐ Newspaper Advertisement _________________ ☐ Internet ____________________________________

☐ HHCI Graduate___________________________ ☐ HHCI Website ______________________________

☐ 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 admission requirements.

In the event that I am accepted, I agree to abide by the student policies and procedures contained in the School Catalog and Consumer Disclosure Information. 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 program. I hereby authorize Harmony Health Care Institute to verify the information provided in the application along with all supporting documents.

____ ___________________________

Applicant's Signature Date