Covenant School of Nursing

RN Program CHECKLIST

Online Application	Once you complete the online application, print it prior to submitting.
Acknowledgement Form	Read and sign.
High School Transcript/GED	Provide official proof of HS graduation. Can be submitted electronically, mailed, or included in a sealed envelope in your packet.
College Transcripts	Provide official transcripts from ALL colleges you have attended. Can be submitted electronically, mailed, or included in a sealed envelope in your packet.
ATI TEAS Scores	Printed 'Individual Performance Profile' sheet.
Immunization Form	A healthcare provider must complete this form.
Photocopy of ID	Provide a copy of your driver's license or government-issued photo ID.
$50 Application Fee	We accept credit/debit card, check, or money order. No cash is accepted.
If applicable to you	Healthcare certifications, military documentation, letter of standing, proof of permanent residency, declaratory order.
Submit your packet	Place all items in a manila envelope. Deliver in person or mail to 1919 Frankford Ave., Lubbock, TX 79407. Partial packets will not be accepted.

Covenant School of Nursing- Acknowledgement Form

Legal Name (print): _____
(last) (first) (middle) (maiden)

Other last names used: _____

Date of Birth _____ **Social Security No.** _____ - _____ - _____
(mm/dd/yyyy)

The Texas Board of Nursing (BON) may require documentation regarding criminal convictions and/or information regarding substance abuse, mental health treatment, and any disability that might adversely affect the safe practice of professional nursing. Based on this information, the BON may deny licensure as a registered nurse if it sees this to be in the best interest of society. Contact the Admission Officer prior to applying if any of these concerns apply to you. Approval from the BON to sit for the registered nursing licensure often takes 6 to 12 months. Written approval from the BON to take the NCLEX-RN (licensing exam) must be on file before an applicant will be granted admission to Covenant School of Nursing. Failure to accurately answer below will result in denial of your admission to CSON.

Have you ever been convicted of a crime (please circle your answer, failure to accurately answer will result in denial of your admission to CSON)? YES or NO

Do you have any criminal charges pending (please circle your answer, failure to accurately answer will result in denial of your admission to CSON)? YES or NO

Criminal Background Check

I authorize Covenant School of Nursing to obtain a criminal background check as part of my admission process, understanding that Covenant School of Nursing will rely upon information it obtains. I understand that information reported through a criminal background check could require me to file a Petition for Declaratory Order with the Texas Board of Nursing. This could be cause for non-admission to Covenant School of Nursing. If a declaratory order is submitted, but no authorization letter from the Texas Board of Nursing is received by the applicant four weeks before beginning the program this is cause for non-admission to Covenant School of Nursing. I also understand that if a report from a consumer reporting agency is the basis from an adverse action, I can be furnished a copy of the report and such additional information as may be required by the law. This authorization shall remain valid until Covenant School of Nursing receives written notice of revocation.

Legal Name (print) _____ **Signature** _____

Functional and/or Learning Disabilities

I understand it is my responsibility to notify Covenant School of Nursing of any functional disabilities which might interfere with my learning and performance as a nursing student and necessitate special accommodations while in school. Furthermore, I understand that if I require special accommodations because of disability, I must request in writing such consideration and submit a current letter from an appropriate licensed professional describing the nature of the functional limitation and specific accommodations needed while a student at Covenant School of Nursing.

Legal Name (print) _____ **Signature** _____

Release and Hold Harmless

I hereby release from any liability all persons and entities who provide information concerning my competence, ethical conduct, character, and other information regarding my qualifications for admission to Covenant School of Nursing. I further fully release and forever discharge Covenant School of Nursing, Covenant Health System, and their servants, agents and employees for their use of and reliance upon any such information obtained and hereby indemnify and hold them harmless from any liability or loss whatsoever, including court costs, attorney's fees, expenses and payment of claims or judgments, which may result from their use of or reliance upon such information.

Legal Name (print) _____ **Signature** _____

Submit this form and required documentation to Covenant School of Nursing, 1919 Frankford Avenue, Lubbock, Texas, 79407

By signing below, I acknowledge that I have read and understand the CSON application requirements. If denied CSON admission, I must resubmit all required documentation and apply again to be reconsidered during the next application cycle and all required documentation must be submitted as well.

Applicant Signature: _____ **Date:** _____

Covenant
School of Nursing

What is the Immunization Verification Form? If an applicant is selected to enter our program, this allows our office to process tentatively accepted students more efficiently.

Where can I go to get this form filled out? Your healthcare provider's office, the Health Department or the Student Health office of your current college. Explain to them that you are applying for a nursing program and are required to have this form completed by a healthcare provider. You might need to gather all shot records and take them to the healthcare provider, if they do not have access. The healthcare provider will verify the information you provide them, by filling out the Immunization Verification Form. It must be completed and signed by a licensed Health Care Provider. Examples are a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility.

Where can I get a copy of my immunization records? Your healthcare provider's office, the Health Department or the Student Health office of the college you are currently attending.

Can I just turn in my shot record? No, this form is required for the application process. A shot record will not be accepted in place of this form.

What if I do not have any documentation of my shot records? If you have no documentation at all, you can have titers drawn for the immunizations that you do not have documentation for. This is a blood draw to check for immunity to each vaccine, and must be done at a healthcare facility or lab.

Please reach out to the Admissions office with any questions!

Covenant School of Nursing

Applicant Name: _____

DOB: _____

Last 4 of SS#: _____

To be completed by a Physician or Other Health Care Provider. Please do not sign the compliance form unless the named person has proper vaccines or immune test. Note: All vaccines administered after September 1, 1991 shall include the MM/DD/YY that each vaccine was given.

Immunization		Option #2	Obtain a Titer "blood draw" from Dr. Office showing "positive" for antibodies/immunity Note: if negative, a booster or vaccine is required.
Measles (Rubeola)*: Two doses of measles-containing vaccine on or after January 1, 1968.	Date#1_____ Date#2_____	**OR** Serologic test positive for measles antibody	Date_____ **(mm/dd/yy)** Results_____
Mumps: One dose of mumps vaccine on or after January 1, 1957.	Date#1_____ Date#2_____	**OR** Serologic test positive for mumps antibody	Date_____ **(mm/dd/yy)** Results_____
Rubella: One dose of rubella vaccine on or after the first birthday.	Date#1_____ **Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.**	**OR** Serologic test positive for Rubella antibody	Date_____ **(mm/dd/yy)** Results_____
Varicella: Two doses of varicella vaccine. **History of Disease is not accepted. Must have Vaccine or Titer.**	Date#1_____ Date#2_____	**OR** Serologic test positive for Varicella antibody	Date_____ **(mm/dd/yy)** Results_____

Three doses of Hepatitis B vaccine. Date#1_____ Date#2_____ Date#3_____ **(mm/dd/yy)**	**OR**	Serology/Titer (lab work results) Date_____ **(mm/dd/yy)** Results_____ **Must include date of test collection and results.**

Tdap (tetanus, diphtheria, pertussis"whooping cough")

One dose of Tdap within the last 10 years. Date_____ **(mm/dd/yy)**

Bacterial Meningitis: For those that are 22 years old or younger.	**MCV-4** Date_____ **(mm/dd/yy)** **OR**	**MPSV-4** Date_____ **(mm/dd/yy)**

To be completed and signed by a physician or other licensed Health Care Provider. Example a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility. Signature:_____ Signature validates all information on this form. Date:	Name of Dr./Office:_____ Address:_____ City: _____State:_____ Phone: