



5. Do you have hands-on patient care experience in a position such as CNA, MA, Respiratory Therapist, EMT, or Surgical Tech?  Yes  No

**IF YES, ASK YOUR SUPERVISOR OR EMPLOYER TO FILL OUT A REFERENCE FORM AND/OR PROVIDE VERIFICATION OF EMPLOYMENT TO RECEIVE THE APPLICATION POINT FOR YOUR EXPERIENCE.**

6. List all places of employment beginning with most recent. (Use additional sheets if necessary.)

•Business Name: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Address: \_\_\_\_\_ Title: \_\_\_\_\_

Supervisor & Phone: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

•Business Name: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Address: \_\_\_\_\_ Title: \_\_\_\_\_

Supervisor & Phone: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

7. Date of actual or anticipated completion of CNA education: \_\_\_\_\_

8. Satisfactory progress through the Practical Nurse Program requires attendance in both theory and clinical sections.

**Clinical hours may include evenings, nights, and weekends.**

Will you commit yourself to the prescribed hours and policies of the Practical Nurse Program?  Yes  No

9. Do you have a prior or pending criminal offense?  Yes  No

(See "Please Note" below.)

10. (Optional) Ethnic Background:  Black Non-Hispanic  Asian or Pacific Islander  Hispanic  
 White Non-Hispanic (Caucasian)  American Indian  Other/Unknown

11. Please list the name, address, and phone numbers of person to be notified in case of emergency.

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please list the name, permanent address, and phone number of your nearest relative or friend not living with you who will always know how to reach you.

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Please Note:**

In order to be licensed as a practical nurse in the State of Utah, the application must be in conformity with the Utah Nurse Practice Act. Applicants who have been convicted of a felony or treated for mental illness or substance abuse should discuss their eligibility status for licensure with the Utah State Board of Nursing.

Acceptance and completion of the nursing program does not assure eligibility to take the PN licensure exam. The Utah State Board of Nursing makes the final decision as to whether a license will be issued to practice nursing in Utah. If you have questions regarding this, please contact the State Board of Nursing,

160 East 300 South, P. O. Box 146741, Salt Lake City, UT 84114-6741, Phone number (801-530-6628).

## **APPLICATION CHECKLIST – Please read thoroughly**

Send completed application including:

- Official (sealed) transcripts from all schools where you have college credit** (within the last 6 years, any completed program requirements, and/or any colleges where you have concurrent enrollment credits). **Official transcripts from the original school are required even if the credits have been transferred and show up on another college’s transcript.** If you do not have 15 credit hours of college work, include an official high school transcript. Transcripts must have semester grades posted (if you have taken any classes that semester) to get credit. If you have transcripts mailed, make sure they say “**ATTN: Practical Nurse**” in the address or we will not receive them and you will need to resend them. Electronic transcripts can be sent to **NursingAdvisor@datc.edu**.
- A current copy of your Certified Nursing Assistant (CNA) state certification, with expiration date, if you have completed it. Points will be awarded for CNA state certification that is current during the application period you are applying for.
- If you have past or present experience working in the medical field, ask your supervisor or employer to fill out a reference form and/or provide Verification of Employment to receive application points for your experience. **These are the only two ways to receive credit for medical experience.**
- Three references must be from **former/current supervisors, teachers, or employers.** ***Applications that include less than three references or references from co-workers, family friends, relatives, or religious leaders will not be accepted and will be disqualified.*** Send or hand-deliver the attached Practical Nurse Reference Form to each person you are using as a reference. Also provide them with an envelope and ask them to write their signature across the sealed back of the envelope. Return these envelopes **with** your nursing application. Write the names, addresses, and phone numbers of your three references on the provided form and include it with your nursing application.
- A **one-page**, typewritten, personal letter describing why professionalism in nursing is important.
- Non-refundable application fee of \$35. Make check or money order payable to “DATC Practical Nurse”
- Review the Functional Requirements for Student Success online at [www.datc.edu/practical-nurse](http://www.datc.edu/practical-nurse). It is located in the Admissions Requirements link.

**Applications can be turned into Student Services or mailed and postmarked by the deadline to:  
Davis Applied Technology College  
Practical Nurse Program Application  
550 East 300 South  
Kaysville, UT 84037-2699**

### **PN PROGRAM ADMISSION REQUIREMENTS:**

1. 18 years old and graduated high school (or equivalent)
2. Cumulative Grade Point Average (GPA) of 3.0 or higher
3. Completion of all application materials
4. Completion of prerequisite requirements by start of PN program
5. The Admissions Committee will conduct an interview process with select applicants
6. If accepted, students will be notified to complete a FBI background check and will be drug screened at random

**Note:** You will be informed by mail as to your status in the Practical Nurse program approximately 6 weeks after the deadline. Please be aware that alternates frequently become accepted as entrants within weeks or days of the beginning of class work, so keep taking courses to meet program requirements.

**I do hereby certify that the statements in this application are true to the best of my knowledge. I give the DATC Practical Nurse Program faculty/staff permission to contact my provided references.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**DAVIS APPLIED TECHNOLOGY COLLEGE  
PRACTICAL NURSE PROGRAM  
REFERENCE INFORMATION**

References must be from former/current supervisors, teachers, or employers.  
***APPLICATIONS THAT INCLUDE LESS THAN THREE REFERENCES OR REFERENCES  
FROM CO-WORKERS, FAMILY FRIENDS, RELATIVES, OR RELIGIOUS LEADERS WILL  
NOT BE ACCEPTED AND WILL BE DISQUALIFIED.***

1. Reference Name: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Association with reference: \_\_\_\_\_
  
2. Reference Name: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Association with reference: \_\_\_\_\_
  
3. Name: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Association with reference: \_\_\_\_\_

**Turn in the completed reference information sheet with your application.**

**DAVIS APPLIED TECHNOLOGY COLLEGE  
PRACTICAL NURSE PROGRAM  
REFERENCE FORM**

**Section A:** This information is to be filled out by the applicant requesting the reference.

Name of Applicant: \_\_\_\_\_

Name of Evaluator: \_\_\_\_\_ Evaluator Phone #: \_\_\_\_\_  
*Please print*

**Section B:** This information is to be filled out by the evaluator. The evaluator should **sign the back of the envelope** over the envelope's seal when the evaluation is completed.

To the Evaluator: You have been selected to supply a reference for the applicant named above for the Practical Nurse Program. This will become part of the applicant's file and thus will be available to him/her should the request be made as guaranteed by the Family Educational Rights and Privacy Act of 1974 and its amendments.

Please circle your evaluation choice on the numerical rating scale of each of the following as it relates to the applicant's potential for nursing. *Comments in each area are helpful.*

1. **Communication: Verbal & nonverbal:** **Comments**

1	2	3	4	5	6	7
Inadequate		Limited skills		Good		Excellent

2. **Interpersonal Relationships:** **Comments**

1	2	3	4	5	6	7
Inadequate		Limited skills		Good		Excellent

3. **Appearance/Grooming:** **Comments**

1	2	3	4	5	6	7
Untidy		Sometimes tidy		Clean/neat		Always well-groomed

4. **Motivation:** **Comments**

1	2	3	4	5	6	7
Poor		Fair		Good		Excellent

5. **Integrity:** **Comments**

1	2	3	4	5	6	7
Dishonest		Sometimes honest		Honest; truthful		Always honest; trustworthy

6. **Punctuality/Absenteeism:** **Comments**

1	2	3	4	5	6	7
Frequently late or absent		Sometimes present & punctual		Good attendance; & punctuality		Excellent attendance; Always punctual

7. Dependability/Responsibility/Maturity:

Comments

1	2	3	4	5	6	7
Immature; undependable; irresponsible		Sometimes mature; dependable; responsible		Mature; dependable; responsible		Always dependable; assumes responsibility very well; very mature

8. Problem Solving/Decision Making/Critical Thinking:

Comments

1	2	3	4	5	6	7
Inadequate		Limited skills		Good		Excellent

9. Anxiety Level:

Comments

1	2	3	4	5	6	7
Very stressed		Stress level average; some-what anxious		Deals with stress well; no evidence of anxiety		Calm; in control in stressful, anxiety- provoking situations

10. Caring Attitude:

Comments

1	2	3	4	5	6	7
Rarely considers other's needs		Sometimes demonstrates caring behaviors		Has a positive attitude; demonstrates caring behaviors		Exceptional attitude of caring for & about others

Additional comments you may wish to make:

*Choose one of the following:*

- I highly recommend this applicant to the Practical Nurse Program.
- I recommend this applicant to the Practical Nurse Program.
- I do not recommend this applicant to the Practical Nurse Program.

*Please answer the following questions regarding the applicant:*

- Yes     No    Has this applicant worked as a CNA, Respiratory Therapist, EMT, Surgical Tech, Paramedic, Medical Assistant, Home Health Aide, Pharmacy Tech, or Radiography Technician at YOUR facility? **(If yes, please circle the applicant's job title.)**
- Yes     No    Has this applicant worked at your facility for six (6) months or more?
- Yes     No    Would you claim this applicant is *very good or excellent* in fulfilling his/her responsibilities?

Evaluator's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Evaluator's Place of Employment: \_\_\_\_\_

Length of time you have known this applicant: \_\_\_\_\_

Capacity in which you have known this applicant: (please circle one)

Supervisor                  Teacher                  Employer                  RN Supervisor                  Other \_\_\_\_\_

**\*References from co-workers, family friends, relatives, or religious leaders will not be accepted**

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