

UNIVERSITY OF ROCHESTER SCHOOL OF NURSING

Accelerated Masters Program for Non-Nurses

Web Page Address: www.son.rochester.edu

Thank you for your interest in the University of Rochester School of Nursing. **The application deadline is July 1st when applying for January (spring) admission and November 1st when applying for May (summer) admission.** Applications received after that date will be considered on a space-available basis (**admission is twice per year – Spring/Summer Sessions ONLY**). We will not begin the application process and your rank will stand incomplete until all of the following information is received.

A complete application consists of the following:

- The completed application form.
- An **official** transcript from **each** college or university attended. **Unofficial or student copies of transcripts are not acceptable.**
- Two letters of reference which address professional and/or academic ability:** Forms are enclosed for your use and it is strongly recommended that your reference use their official letter head. **All references need to be in a sealed envelope and signed by the preparer.**
- A non-refundable \$50 (U.S.) application fee. Make your check or money order payable to the University of Rochester School of Nursing and enclose the fee with your application.
- Current copy of Curriculum Vitae or Resume
- Typewritten Professional Goal Statement
- Response card

Send all application materials to: Nancy Kita, University of Rochester School of Nursing,
Office of Student Affairs, Box SON, Rochester NY 14642, in the enclosed envelope.

Questions may be directed to the School of Nursing Office of Student Affairs at (585) 275-2375.

The University of Rochester values diversity and is committed to equal opportunity for all persons regardless of age, color, disability, ethnicity, marital status, national origin, race, religion, gender, sexual orientation or veteran status. Further, the University complies with all applicable non-discrimination laws in the administration of its policies, programs and activities. Questions on compliance should be directed to the particular school or department and/or to the University's Equal Opportunity Coordinator, University of Rochester, P.O. Box 270039, Rochester NY 14627. Phone: (585) 275-9125.

UNIVERSITY OF ROCHESTER SCHOOL OF NURSING

Application for Admission Accelerated Master's Program for Non-Nurses AMPNN

Name: _____
Last First Middle

If transcripts are under another name, please give that name: _____

Social Security Number: ___ - ___ - ___ Gender: Male ___ Female ___

Date of Birth: _____ Place of Birth: _____

Current Address: _____

Permanent Address: _____

If New York State, what county: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____

Emergency contact: _____
Name Phone No. Relationship

Country of Citizenship: _____ Type of Visa (if applicable): _____

Are you employed by the UR/SMH/HH: No ___ Yes ___ (unit _____)

Are you applying for financial aid: Yes ___ No ___ Will use tuition benefits: _____

Do you wish to be considered for university housing: Yes ___ No ___

Names of any colleges or universities you have attended:

1. _____ Dates attended: _____ Degree: _____

2. _____ Dates attended: _____ Degree: _____

3. _____ Dates attended: _____ Degree: _____

(attach separate sheet if necessary; include name)

Have you completed any courses at UR: Yes _____ (years attended _____)

Please list any courses completed or in progress (prerequisites):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you applied to the UR previously: Yes _____ No _____

If yes, when: _____

Sign here if you would like your UR transcript courses/grades added to your file: _____

When do you plan to enroll at the UR: Year _____ (January _____ May _____)

Please check: Full-time _____ (**there is NO part-time option for the accelerated programs**)

Military Service: Active _____ Veteran _____ Other _____

Please choose the **NP Specialty Program** you're applying for:

- _____ Acute Care Nurse Practitioner
- _____ Acute Care Cardiovascular and Critical Care Nurse Practitioner
- _____ Adult Nurse Practitioner
- _____ Adult Nurse Practitioner/Geriatric Nurse Practitioner
- _____ Family Nurse Practitioner
- _____ Care of Children and Families/Pediatric Nurse Practitioner
- _____ Care of Children and Families/Pediatric Nurse Practitioner with Pediatric Behavioral Health Specialization
- _____ Psychiatric Mental Health Nurse Practitioner (Adult/Family)
- _____ Psychiatric Mental Health Nurse Practitioner (Child/Adolescent)

Citizenship Information: (*Required for government recording)

Non- U.S. Citizens

*Citizen of what country? _____

*Are you a permanent U.S. resident? _____ Yes _____ No

U.S. Citizens Only

Race/Ethnicity: *Are you Hispanic or Latino? _____ Yes _____ No

***Please select one or more races that you identify with from the following:**

- _____ American Indian or Alaskan Native _____ Black or African American
- _____ Native Hawaiian or Other Pacific _____ White
- _____ Asian

CPR Information:

Attach a copy of a current CPR card from the Basic Life Support for the Professional Rescuer offered by the American Heart Association or the American Red Cross. Please indicate below the type of CPR training you have had. **This is a requirement prior to starting the program.** Type of CPR Certification: _____

Please answer the following questions:

1. Have you ever been dismissed from a school, college or university? Yes _____ No _____
2. Have you ever been convicted of a criminal offense? Yes _____ No _____

If you answer **yes** please elaborate on a separate sheet of paper.

Honors and other evidence of scholarship (honor societies, fellowships, awards, etc.) :

International Students Only

For visa purposes:

City and Country of birth: _____ Marital Status: _____

If you are a United States resident, what type of visa do you hold: _____

Transcript evaluation:

Students graduating from any foreign school must have their transcript evaluated by one of the following: **World Education Services**, Bowling Green Station, P.O. Box 5087, New York, NY 10247-5087; E-mail: info@wes.org; Phone: 212-966-6311; Fax: 212-739-6100 or **Educational Credentials Evaluators, Inc.**, P.O. Box 514070, Milwaukee WI 53203-3470; E-mail: eval@ece.org; Phone: 414-289-3400; Fax: 414-289-3411.

Test of English as a Foreign Language (TOEFL):

 score

 date taken

Document References Below

Provide the names, titles, and addresses of two of your present or former instructors, supervisors or employers whom you have asked to recommend you. If you have been employed six months or more, a letter from your supervisor may be used.

Name: _____ Phone: (_____) _____
 Area Code

Title or Position: _____

Business Address: _____
 Street City State Zip Code

Name: _____ Phone: (_____) _____
 Area Code

Title or Position: _____

Business Address: _____
 Street City State Zip Code

Tell us how you became interested in the University of Rochester School of Nursing

Your signature indicates that all the information in this application is factual.

Applicant Signature: _____ **Date:** _____

Professional Goal Statement Must be Typewritten

The purpose of this statement is for you to provide information about yourself as well as to demonstrate your ability to express ideas clearly and logically in a grammatically correct format. You should provide information about yourself, your aims, your plans for the future, and your reasons for wanting to enter the Accelerated Masters Degree program at the University of Rochester School of Nursing. *Please include how you would contribute to student diversity in the UR School of Nursing; for example, you could write about your natural or acquired talents or abilities, career or work experiences, community or volunteer service, educational experiences, exposure to different cultures or ways of life or leadership experiences.* This statement must be typewritten and is limited to 500 words.

Send Letter of Reference to:

Nancy Kita
University of Rochester School of Nursing
Office of Student Affairs
Box SON, 601 Elmwood Avenue
Rochester NY 14642

To be completed by the applicant:

Name of Applicant: _____

First

Middle

Last

Name of Recommender: _____

Title and Employer: _____

I hereby waive my right of access under The Family Education Rights and Privacy Act of 1974 to specific and composite letters of recommendation.

Signature: _____ Date: _____

To be completed by the recommender:

Please complete this form and attach a letter *ON OFFICAL LETTERHEAD* . All information must be provided. The admissions procedure of the University of Rochester School of Nursing requires the applicant to gather individual letters of recommendation plus all other documents and submit a complete set of documents with the application. The advantage of this system is that the student knows the application is complete when submitted. After completing this form, place it in the envelope provided, seal the envelope, sign across the sealed flap and return it to the applicant who will forward it unopened to the School of Nursing.

How long and in what capacity have you known the applicant? _____

A. Please comment on the applicant's strengths and weaknesses for the **Accelerated Masters Degree** program for non-nurses. If you have taught the applicant, your comparison of the applicant's work to that of other students would be helpful. If you have worked with the applicant, your assessment of his or her potential is most valuable. Balanced evaluations generally work to the applicant's advantage.

B. Among those at a similar level whom you have known in recent years, how would you rate this applicant?

____ Among the very best; ____ Top 5%; ____ Top 10%; ____ Top 25%; ____ Top half; ____ Below average

Signature: _____ Date: _____

Name of Recommender (please print): _____

Position, Profession or Occupation: _____

Phone: (____) _____

Area code

Professional Address: _____

Send Letter of Reference to:

Nancy Kita
University of Rochester School of Nursing
Office of Student Affairs
Box SON, 601 Elmwood Ave
Rochester NY 14642

To be completed by the applicant:

Name of Applicant: _____

First

Middle

Last

Name of Recommender: _____

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Signature: _____ Date: _____

Name of Recommender (please print): _____

Position, Profession or Occupation: _____

Phone: (_____) _____

Area code

Professional Address: _____