

**S.S. # (Last four digits)**

**D.O.B (MM/DD/YYYY)**

# OAKLAND UNIVERSITY SCHOOL OF NURSING CONTINUING EDUCATION APPLICATION FOR PATIENT CARE ASSOCIATE PROGRAM

**Personal Information:**

To be completed by applicant. Please print clearly.

|  |  |  |
| --- | --- | --- |
| **Last Name** | **First Name, Middle Initial** | **Maiden/Surname** |
|  |  |  |
| **Street Address** |
|   |
| **City** | **State** | **Zip Code** |
|  |  |  |
| **Cell Phone Number** | **Home Telephone Number** | **Email Address** |
|  |  |  |
| **Emergency Contact** | **Telephone Number** | **Relationship to Applicant** |
|  |  |  |

# Education Background:

Did you graduate from high school or earn your GED? Yes No

Please list in reverse chronological order any previous school, training programs, or colleges attended.

|  |  |  |
| --- | --- | --- |
| **Institution** | **Program of Study** | **Graduate Date** |
|  |  |  |
|  |  |  |
|  |  |  |

# Employment Background:

Please list in reverse chronological order any current employment as well as previous employers.

|  |  |  |  |
| --- | --- | --- | --- |
| **Employer** | **Position** | **Location** | **Dates Employed** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Are you a U.S. Citizen? Yes  No - If no, do you have a Permanent Resident Card: Yes No

If you have a Permanent Resident Card please bring original card at time of submitting application along with your original visa card and passport.

What is your country of birth and country of citizenship?

**(Country of Birth) (Country of Citizenship)**

# PLEASE READ BEFORE SIGNING

I certify that all of the information set forth in this application and supporting materials is complete and accurate. If admitted, I agree to observe all of the rules and regulations of Oakland University. I understand that admission to the university is conditioned upon the accuracy of the information that I have provided on this application. Falsification or misrepresentation of the information or inaccurate information constitutes grounds for dismissal from Oakland University.

# Applicant Signature: Date:

THIS INFORMATION IS VOLUNTARY. TO FULFILL FEDERAL AND STATE REPORTING REQUIREMENTS THE SCHOOL OF

NURSING IS REQUIRED TO ASK FOR THIS DATA. THE INFORMATION WILL NOT BE USED IN THE SCHOOL OF

NURSING ADMISSION PROCESS.

Birth Day:

Gender (Check One): Male □ Female □

Month Day Year

Racial/Ethnic Background (If your background is multi-cultural, indicate the category with which you most identify):

|  |  |  |
| --- | --- | --- |
|  White/NON Hispanic |  Asian/Pacific Islander |  Hispanic |
|  Black/NON Hispanic |  Native American/Alaskan Native |  Other (Please Specify) |

Oakland University, as an equal opportunity and affirmative action institution, is committed to compliance with federal state laws prohibiting discrimination, including title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 and section 504 of the Rehabilitation Act of 1973. It is the policy of Oakland University that there shall be no discrimination on the basis of race, sex, color, religion, national origin or ancestry, age, marital status, handicap, veteran status or other prohibited factors in employment, admissions or other activities.

**Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Student Eligibility Requirements

|  |  |  |
| --- | --- | --- |
| **Eligibility Requirements – COMPLETE STEPS 1-3** | **Record on File Y/N** | **OU Staff Initial & Date** |
| **Step #1** |  |  |
| Completed Application |  |  |
| Goal Statement: One Page (See pg. 3) |  |  |
| High School Diploma or GED (Copy) |  |  |
|  |  |  |
| **Step #2** |  |  |
| Criminal Background Check **($10.00)** [**(htt**](http://apps.michigan.gov/ichat/home.aspx%29)**p**[**://apps.michigan.gov/ichat/home.aspx)**](http://apps.michigan.gov/ichat/home.aspx%29) |  |  |
|  |  |  |
| **Step #3 –**  |  |  |
| Influenza Vaccine |  |  |
| TB Skin Test |  |  |
| Health Assessment |  |  |
| Titers including Varicella |  |  |
| 10 Panel Urine Drug Screen |  |  |

**Goal Statement**

Please discuss briefly why you would like to become a Patient Care Associate and how you plan to contribute to the nursing profession (500 word count, must be professional and typed). **(Please include a copy with the Application Package)**

**Forward Completed Application Package to:** Oakland University School of Nursing Continuing Education Patient Care Associate Program

Attn: Admissions Department 1360 Oakman Blvd – 2nd Floor Detroit, MI 48238