

# Instructions

We are pleased you are interested in completing your bachelor of science in nursing degree to enhance your skills and advance your career in health care. Please follow these instructions for completing the application process for admission to Capital's School of Nursing.

## Admission Requirements

1. Current Ohio RN licensure
2. Graduate of an accredited associate degree or diploma nursing program
3. Undergraduate GPA of 2.5 or better on a 4.0 scale
4. Receipt of all post-secondary official transcripts

## To complete the application process

1. Make sure you have completed all parts of the application form and have signed and dated it.
2. Enclose a \$25 non-refundable fee. (Check should be made payable to Capital University.)
3. Return the application and fee to:  
Capital University – School of Nursing  
BSN-Completion Program  
1 College and Main  
Columbus, OH 43209-2394
4. Request that official transcripts of all previous college/university work and financial aid information be sent directly to the above address.

If you have questions regarding the admission process, please feel free to contact the BSN-Completion Program at:

Telephone • (614) 236-6345  
Fax • (614) 236-6157  
E-mail • [sstocker@capital.edu](mailto:sstocker@capital.edu)

Capital University admits qualified students regardless of race, color, religion, gender, age, disability or national or ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the university.

For admission:	<input type="checkbox"/> Columbus	<input type="checkbox"/> Fall	20__
	<input type="checkbox"/> Dayton	<input type="checkbox"/> Spring	
		<input type="checkbox"/> Summer	

## Personal Data

Name \_\_\_\_\_  
(Mr./Mrs./Ms./Miss) (Last) (First) (Middle) (Maiden)

Home address \_\_\_\_\_  
(Street) (City) (State) (ZIP)

Home telephone (\_\_\_\_) \_\_\_\_\_ E-mail address \_\_\_\_\_ Pager/cell (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_  
(Name) (Address)

Job title \_\_\_\_\_ Business telephone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Does your employer offer tuition reimbursement?  Yes  No  Not sure

Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Citizenship \_\_\_\_\_

Social Security number \_\_\_\_\_ Ohio RN licensure # \_\_\_\_\_

Other RN licensure \_\_\_\_\_ Specialty certification \_\_\_\_\_  
(License number) (State) (Expiration) (If applicable)

Predominant ethnic background (This information is used for statistical purposes only.)

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> African-American          | <input type="checkbox"/> Caucasian/Non-Hispanic | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Native American        | <input type="checkbox"/> Other    |

Religious preference (This information is used for statistical purposes only.)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Baptist        | <input type="checkbox"/> Lutheran           | <input type="checkbox"/> United Church of Christ |
| <input type="checkbox"/> Episcopal      | <input type="checkbox"/> Methodist          | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Greek Orthodox | <input type="checkbox"/> Protestant (other) | <input type="checkbox"/> No religious preference |
| <input type="checkbox"/> Jewish         | <input type="checkbox"/> Roman Catholic     |  |

How did you learn about our program?

- |                                     |  |  |   |
|-------------------------------------|--|--|---|
| <input type="checkbox"/> U.S. mail  | <input type="checkbox"/> E-mail        | <input type="checkbox"/> Newspaper     | <input type="checkbox"/> Radio                        |
| <input type="checkbox"/> Television | <input type="checkbox"/> Search engine | <input type="checkbox"/> Word of mouth | <input type="checkbox"/> Other (Please specify _____) |

Name, address and phone number of someone through whom you always can be contacted:

\_\_\_\_\_  
(Name) (Address) (Phone number)

## Previous Education

Have you ever attended Capital University?  Yes  No (If yes, when? \_\_\_\_\_)

List chronologically all schools you have attended

Dates of attendance	Name and address of institution	Degree/credits earned
_____	_____ (High school)	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This application must be supported by official transcripts of all work completed to date. Please request the registrar of each institution attended to forward your official records to the Capital University School of Nursing. For planning purposes, you may submit copies of unofficial transcripts with this application and follow up with official transcripts.

## In your own words

1. What are your personal and professional goals?

2. What are your reasons for enrolling in Capital University's BSN-Completion Program?

Have you ever been suspended or expelled from any high school or college/university?  Yes  No

Have you ever been convicted of or pled guilty to a felony?  Yes  No

(If you answered yes to either of the above questions, please attach a statement of explanation.)

I certify that the information provided in this application is complete and correct to the best of my knowledge.

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

