

**LAGRANGE COLLEGE – DEPARTMENT OF NURSING
APPLICATION FOR ADMISSION TO THE RN-BSN DEGREE COMPLETION PROGRAM**

NAME SS# BIRTHDATE

STREET ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE

1. Name of nursing school (s) attended: _____
 Address of school (s): _____
 Year and month of graduation: _____
 Was your school NLN accredited? _____
Yes No Unsure

2. Registered Nurse licensure in the state of: _____
 Expiration date of RN license: _____
 Are any restrictions placed on your license? _____
Yes No

If yes, please give the nature of the restriction:

3. Clinical practice as an RN for the past three years:

YEAR	POSITION	EMPLOYER	APPROXIMATE # OF HOURS PER YEAR

