

DANVILLE REGIONAL MEDICAL CENTER  
SCHOOL OF HEALTH PROFESSIONS

142 South Main Street  
Danville, Virginia 24541

APPLICATION FOR ADMISSION

- This application must be accompanied by a non-refundable \$35 application fee (Checks or money orders only).
  - Please make checks or money orders payable to: DRMC School of Health Professions and include the applicants first and last name in the memo section of the check. Please do not mail cash!
  - In order to reduce delays and potential errors, please place all documents in a sealed envelope marked CONFIDENTIAL and mail as one complete packet.
- Applicants are selected in accordance with non-discriminatory policies.
- Due to limited enrollment, applicants who meet all requirements are not guaranteed acceptance into this program.

The Admissions Committee will review only applicant files that are complete. It is the applicant's responsibility to ensure that the school receives all required documentation. After selections have been made, all applicants will be notified whether selected, not selected, or placed on an alternate list. Selected applicants will be required to submit an admission fee; successfully complete any remaining prerequisite courses; undergo drug screening and criminal background check; submit a completed health assessment form, immunization record, and current CPR certification .

PROGRAM TO WHICH YOU ARE APPLYING: (check only one)

- Nursing RN (2 year)                      Application due by: March 15<sup>th</sup>
- LPN – RN Bridge                              Application due by: August 1<sup>st</sup>
- Radiologic Technology                      Application due by: July 15<sup>th</sup>

APPLICANT INFORMATION

Date \_\_\_\_\_ Desired Year of Admission \_\_\_\_\_ Social Security Number \_\_\_\_\_

Name \_\_\_\_\_  
*Last First Middle Maiden*

If different, include your last name as it appears on your High School and/or college transcript:

Mailing Address \_\_\_\_\_  
*Street City State ZIP Code County*

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_ Are you a United States citizen?  Yes  No

In case of an emergency, call \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Have you ever been convicted of or are you presently under indictment for any felony or misdemeanor offense other than traffic violations? \*  Yes  No If yes, please explain in an attached letter.

**\*Information is subject to verification through a Criminal History Record check.**

Attention Applicants: The Board of Health Professions "may refuse to admit a candidate to any examination, or may refuse to issue a license or certificate to any applicant" based on a number of both criminal and/or unprofessional conduct reasons.

Do you have a mental, physical or chemical dependency condition, which could interfere with your current ability to practice in the healthcare field?

Yes  No **If you answered yes, please explain in detail on a separate sheet and attach to this application.**

(Note: The DRMC School of Health Professions is firmly committed to maintaining an environment free of the influence of illegal drugs and alcohol. The School maintains the right to require any student to undergo testing to determine his or her fitness for duty, such as to determine whether the student may pose a potential danger of harming patients or may have a medical problem that interferes with his or her ability to perform duties safely or effectively. In keeping with this practice, a student may be tested for drugs or alcohol to help determine that person's fitness for duty. For more information, please refer to the School of Health Professions Policy on Illegal Drugs and Alcohol.)

**EDUCATION**

Please request transcripts from **each** institution you attended.

Do you have a high school diploma?  Yes  No If not, do you have a G.E.D.?  Yes  No

High School Attended \_\_\_\_\_

City/State \_\_\_\_\_ Graduation Date \_\_\_\_\_

List in chronological order **all** colleges, universities, and vocational/technical schools which you have attended.

1. Name of School \_\_\_\_\_ City/State \_\_\_\_\_

Dates Attended: *From* \_\_\_\_\_ *To* \_\_\_\_\_ Graduation Date \_\_\_\_\_

Degree Obtained: \_\_\_\_\_

2. Name of School \_\_\_\_\_ City/State \_\_\_\_\_

Dates Attended: *From* \_\_\_\_\_ *To* \_\_\_\_\_ Graduation Date \_\_\_\_\_

Degree Obtained: \_\_\_\_\_

3. Name of School \_\_\_\_\_ City/State \_\_\_\_\_

Dates Attended: *From* \_\_\_\_\_ *To* \_\_\_\_\_ Graduation Date \_\_\_\_\_

Degree Obtained: \_\_\_\_\_

Have you previously attended or applied to this program?  Yes  No

Have you attended another school or program similar to this one?  Yes  No

Are you a licensed practical nurse?  Yes  No

If yes, what school did you attend? \_\_\_\_\_

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

Have you ever applied for licensure or certification in Virginia or another state?  Yes  No

If yes, and you took the licensing examination, give the date, and indicate whether or not you passed.

Practical Nurse State \_\_\_\_\_  Yes  No Date(s) \_\_\_\_\_ Passed  Yes  No

Certified Nurse Aid State \_\_\_\_\_  Yes  No Date(s) \_\_\_\_\_ Passed  Yes  No

Has your license ever been?

Voluntarily surrendered to any licensing authority?  Yes  No

Placed on probation?  Yes  No

Suspended?  Yes  No

Revoked?  Yes  No or

Otherwise disciplined?  Yes  No?

Has your practice ever been the subject of an investigation by any licensing board?  Yes  No

**If you answered yes to any of the above questions, explain in detail on a separate sheet and attach to this application.**

## EMPLOYMENT HISTORY

Include all employment within the past five years, beginning with your present or last employment.

1. Employer \_\_\_\_\_  
 City/State \_\_\_\_\_ Job Responsibilities \_\_\_\_\_  
 \_\_\_\_\_ Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_  
 Reason for Leaving \_\_\_\_\_
2. Employer \_\_\_\_\_  
 City/State \_\_\_\_\_ Job Responsibilities \_\_\_\_\_  
 \_\_\_\_\_ Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_  
 Reason for Leaving \_\_\_\_\_
3. Employer \_\_\_\_\_  
 City/State \_\_\_\_\_ Job Responsibilities \_\_\_\_\_  
 \_\_\_\_\_ Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_  
 Reason for Leaving \_\_\_\_\_

## PREREQUISITE COURSES

### Nursing Program

A minimum of 10 semester hours of the college level prerequisites must be completed with grades of "C" or above before enrollment. These must include Biology 231 and Biology 232 (Anatomy and Physiology I and II) or their equivalent, and Math 126 (RN) (must be completed at DCC within 12 months prior to enrollment). Note: for the LPN – RN Bridge Program all college course work, except MDL 195, must be completed prior to enrollment.

**Please indicate your current status in the following college courses.**

Course	Section Number	Semester Hours	STATUS	
			Presently Enrolled	Completed (Include grade and school)
Human Anatomy and Physiology I	BIO 231	4		
Human Anatomy and Physiology II	BIO 232	4		
Math for Allied Health	MATH 126	2		
English Composition I	ENG 111	3		
Introduction to Sociology I	SOC 201	3		
Topics in Microbiology	MDL 195	2		
General Microbiology (optional)	BIO 205	4		
Introduction to Psychology I	PSY 201	3		

### Radiologic Technology Program

**Please indicate your current status in the following college courses.**

*Human Anatomy and Physiology I	<b>Please see the Rad Tech  <i>Transfer Guide</i> on the  <i>Admission Requirements</i>                      page and call the Program                      Director for specific                      information regarding                      general education courses!</b>	4		
*Medical Terminology		2-3		
English Composition I		3		
Computer Elective		2-3		
Mathematics Elective		3		
Social Science Elective		3		
Humanities Elective		3		
<i>Human Anatomy and Physiology II                      Recommended</i>		3		
<b>*Pre-Requisite Courses (must be completed by end of Fall term),                      Please check with the Program Director @ (434)799-2271 before enrolling in any general education courses!</b>				

## REFERENCES

Submit three (3) completed professional or academic reference sheets (such as a recent employer, teacher, and/or counselor.), **not relatives, friends, or clergy**. Each person serving as a reference must complete the form, place it in an envelope, seal the envelope and sign across the back flap, and return the sealed envelope to you. Include these sealed envelopes with your application. References not meeting the above criteria are considered invalid.

## DISCLOSER

### CERTIFICATION, ACKNOWLEDGEMENT, AND AUTHORIZATION:

Please read the following statement carefully before signing.

I certify that the information contained in this application is true and complete. I understand that if I am found to have provided false or incomplete information on this application, the Program may cancel my application or, if I have been accepted, remove me from the Program.

I understand that if I am enrolled in the DRMC School of Health Professions, I will be subject to and required to abide by all of the School's policies, procedures, and practices, including (among others) their Program on Illegal Drugs and Alcohol. I agree that I will abide by these policies, procedures, and practices, including any that the School may add or modify during my enrollment.

I understand and acknowledge that the DRMC School of Health Professions has a legitimate need to know the details of my education and employment history in order to consider my application. I hereby authorize and request for my former schools, employers, and other institutions or persons with information about my education and employment history to provide to the DRMC School of Health Professions any information or records the School may request about my education or employment history. I hereby release from any liability of any kind any institution, company, or person who provides such information or records and any authorized representative of the School who requests such information or records.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

## STUDENT ESSAY

### On a separate sheet, please write a brief essay addressing each of the following:

- Your experiences and activities including awards/honors, volunteer or community service
- Your reason for selecting this career and your reason for desiring to enter this school
- Your perception of your intellectual capability to complete this program
- Your plans and aspirations for the future
- Why do you think communication and critical thinking are important skills for a health professional to possess.

## STATISTICAL INFORMATION

This information is optional and used for statistical purposes only. The data is reported to Danville Regional Medical Center School of Health Professions. It does not affect your eligibility for admission.

Birth Date:

\_\_\_/\_\_\_/\_\_\_

Predominant Ethnic Background:

American Indian or Alaskan Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Hispanic or Latino

Marital Status:

Single

Married

Separated

Divorced

Widowed

Sex:

Male

Female

Number of Children \_\_\_\_\_ Ages of children: \_\_\_\_\_

Are you the head of the household?  Yes  No

Do you plan to be employed while enrolled in the Program?  Yes  No

If yes, in what status?  Full Time  Part Time