GRIFFIN HOSPITAL
SCHOOL OF ALLIED HEALTH CAREERS

Medical Office Building
300 Seymour Ave
Ste. 201A Derby, CT 06418-1343
P: (203) 732-7147
F: (203) 734-1132
PNProgram@griffinhealth.org

☐ **Check if OHE qualified as a Stone "Transfer/TeachOut" student. Only complete Parts 2, 3, 8B and 9**

Practical Nursing Program Application

Part I: Application Requirements:

☐ ≥ 18 years of age at time of program start
☐ Diploma or highest degree earned
☐ Completed *Practical Nursing Program Application*
☐ Application fee $100.00 (non-refundable) **Application will not be reviewed until fee is paid**
☐ Online applications **only**, no handwritten applications will be accepted

All applicants who meet the minimum stated requirements listed above and pass the initial application review must undergo an admissions interview prior to the school rendering a decision regarding the applicant's acceptance. Acceptance offers will be contingent upon the applicant obtaining a sufficient score on the HESI A2 Entrance Exam and receiving favorable screening results from the physical health and drug/toxicity screens.

Part 2: Applicant Information:

Name: Last Name | First Name | Middle Initial
Last | *First* | *M.I.*

Address: Street Address | Apt/Unit #
Street | *Apt/Unit #*
City | State | Zip Code
City | *State* | *Zip Code*

Contact: Phone | E-mail address

Emergency Contact: Phone | Relationship | First & Last Name

Part 3: Background Information:

Are you a U.S. citizen? Yes ☐ No ☐

If no, are you authorized to work in the United States? Yes ☐ No ☐

Do you or have you worked for Griffin Health/Griffin Hospital? Yes ☐ No ☐

If yes, when and in what capacity? Click or tap here to enter text.

Have you even been convicted of a felony? Yes ☐ No ☐

If yes, please attach a separate page (typed) that includes the date of each incident, explains the circumstances, and reflects upon what you learned from the experience.

Additional demographic information: The questions in this section are optional. Information you provide will not be used in a discriminatory manner and is not factored into acceptance decisions.

For each question, please select all that apply to you and your identity.
With what gender do you identify? Select all that apply:

- ☐ Female
- ☐ Male
- ☐ Nonbinary or gender nonconforming
- ☐ Prefer not to say

With what race and/or ethnicity do you identify? Select all that apply:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latinx
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other not listed: Click or tap here to enter text.
- ☐ Prefer not to say

Part 4: Education

High/Secondary School: Name of School **Address:** School Address

From: Click to enter a date **To:** Click to enter a date **Did you graduate?** **YES** ☐ **NO** ☐ **Diploma:** Diploma Received (e.g. High School, GED, etc.)

Please attach a copy of diploma and/or official transcripts*

College/ University: Name of School **Address:** School Address

From: Click to enter a date **To:** Click to enter a date **Did you graduate?** **YES** ☐ **NO** ☐ **Degree** Choose an item.

Please attach a copy of diploma and/or official transcripts*

Other: Name of School **Address:** School Address

From: Click to enter a date **To:** Click to enter a date **Did you graduate?** **YES** ☐ **NO** ☐ **Degree:** Choose an item.

Please attach a copy of diploma and/or official transcripts*

If more space is needed, please attach additional sheets

Part 5: Work & Other Related Experiences

Company: Company Name **Phone:** Company Phone #

Address: Company Address **Supervisor:** Supervisor's Name

Job Title: Job Title **Dates of Service:** MM/YY – MM/YY

Responsibilities: Briefly describe your job responsibilities

Company: Company Name **Phone:** Company Phone #

Address: Company Address **Supervisor:** Supervisor's Name

Job Title: Job Title **Dates of Service:** MM/YY – MM/YY

Responsibilities: Briefly describe your job responsibilities

Company: Company Name **Phone:** Company Phone #

Address: Company Address **Supervisor:** Supervisor's Name

Job Title: Job Title **Dates of Service:** MM/YY – MM/YY

Responsibilities: Briefly describe your job responsibilities

If more space is needed, please attach additional pages.

Part 6: Professional References & Letters of Recommendation

Please list two professional references. These may include teachers, guidance counselors, supervisors, employers, etc. ***Relatives and friends are NOT acceptable references****. Please request each reference write a letter of recommendation indicating why they feel the applicant is a strong candidate for the Griffin Hospital School of Allied Health Careers Practical Nursing Program. Letters submitted via hardcopy must be in a sealed envelope with the author's signature across the closed seal. Alternatively, references can email their letters to PNprogram@griffinhealth.org, fax them to (203) 734-1132, or mail them to:*

Griffin Hospital School of Allied Health Careers
Attn: Practical Nursing Program
300 Seymour Ave Ste 201A
Derby, CT 06418-1343

Reference Contact Information:

Full Name: Full Name Relationship: Relationship to Applicant

Company: Name of Organization Phone: Phone #

E-mail: Preferred E-mail Address

Full Name: Full Name Relationship: Relationship to Applicant

Company: Name of Organization Phone: Phone #

E-mail: Preferred E-mail Address

Part 7: Personal Statements

Note: Please answer each part separately.

Part I

On a separate page, submit a typewritten essay answering one of the questions listed below. A typewritten essay will help us become acquainted with you and demonstrate your ability to organize and process your thoughts when expressing yourself. Your essay should be 500-600 words in length. Please choose from one of the following topics, and indicate which question you are answering:

1. Describe a significant experience, achievement, or ethical dilemma you have faced and its impact on you.
2. The lessons we take from obstacles we encounter can be fundamental to later success. Recount a time when you faced a challenge, setback, or failure. How did it affect you, and what did you learn from the experience?
3. Describe a problem you've solved or a problem you'd like to solve. It can be an intellectual challenge, a research query, an ethical dilemma – anything that is of personal importance, no matter the scale. Explain its significance to you and what steps you took or steps that could be taken to identify a solution.

Part II

On a separate, typewritten page, write one to two paragraphs discussing why you want to attend nursing school.

Part 8 A: Additional Documentation

Please attach the following documents to your application:

(Please note no Google Docs or screenshots accepted – must be PDF or Word file)

- ☐ Professional Resume
- ☐ Copy of diploma for any currently held degrees
- ☐ Copy of transcripts for schools or academic programs attended
- ☐ Copy of birth certificate, license, passport, or other official documentation that contains proof of date of birth
- ☐ All of the above documentation **must** be included in one email along with this application.

Part 8 B: Additional Documentation for Stone "Transfer" students ONLY

Please attach the following documents to your application:
(Please note no Google Docs or screenshots accepted – must be PDF or Word file)

- ☐ Copy of your official, audited transcript from Stone Academy/Office of Higher Education

The following is required and will be accepted if results are within ONE YEAR:

- ☐ Copy of background check
- ☐ Copy of toxicology screening
- ☐ Physical and immunizations, including Covid vaccination and booster.

If the above is ***not*** within one year, you must provide us with current documents per the below:

- Background checks through **CastleBranch** (Cost is $64).
- Drug screenings through Griffin's **Occupational Medicine** (Cost is $45).
- Student Health Form

Please refer to pages 6-10 for instructions for the above.

Part 9: Application Fee

All applications must be accompanied by the $100 non-refundable application fee.

Applications cannot be reviewed until the fee is paid.

Please indicate below how you plan on paying the application fee:

- ☐ Credit card (please call 203.732.7147 to pay over the phone)
- ☐ Cash (please pay in person)
- ☐ Check (please pay in person or mail to the address below):

School of Allied Health Careers Practical Nursing Program
300 Seymour Ave
Suite 201A
Derby, CT 06418-1343

The School of Allied Health Careers is NOT responsible for payment sent & lost in the mail

Part 10: Attestation & Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to acceptance, I understand that false or misleading information in my application or interview may result in release from the Griffin Hospital School of Allied Health Careers Practical Nursing Program.

Signature: _____ **Date:** _____

Griffin Hospital School of Allied Health Careers does not discriminate, nor will tolerate from other disciplines, discrimination on the basis of race, color, national or ethnic origin, religion, age, gender, marital status, sexual orientation, handicap, veteran status, gender identify or any other basis prohibited by law in the administration of its educational policies, admission policies, scholarship and loan program, and other programs administered by the School of Allied Health Careers.

Thank you for applying to the Griffin Hospital School of Allied Health Careers Practical Nursing Program. We look forward to reviewing your application.

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How to Schedule Your Background Check

Griffin Health Services Corporation portal link:

- Portal.castlebranch.com/GQ97
- Select "Place an Order"
- Package Code is = GQ97BG
- Choose = Package #1 (background check ONLY)

CastleBranch

Cost:

$64

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How to Schedule Your Toxicology Screening

Call:

Griffin Occupational Medicine & Rehabilitation Services and ask to schedule a toxicology screening appointment. Tell them you are a student at the School of Allied Health Careers.

Griffin Occupational Medicine & Rehabilitation Services

10 Progress Drive Shelton, CT 06484-6216

Phone: 203-944-3718 | Fax: 203-929-3068

Hours:

Monday-Friday, 7:00 am – 5:00 pm

Cost:

$45

Bring with you:

License or other photo ID
Payment

Results:

Will take a couple of days. If on prescription medication, may take longer.

Additional note:

If you would like to do your toxicology screen through a different provider, that is okay but the provider MUST fax the School of Allied Health Careers Practical Nursing Program a copy of the results, they cannot be hand delivered by the student. Our fax number is **203-734-1132**.

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Practical Nursing Program Student Health Form

Instructions

- All students are required to have a completed health form on file to be able to participate in classroom and clinical experiences.
- Forms must be submitted to the Allied Health Coordinator at least **two weeks prior to the start of classes**.
- Completed forms can be submitted in person or via fax, email or mail.
- Should a student's health status change in such a way that it impacts their ability to meet the requirements of the nursing program, the student must promptly notify the Program Director.
- Student checklist:

Physical Exam
- Must be completed on School of Allied Health Physical Exam Form (page 2) by provider

COVID-19
- Documentation of completed primary vaccine series ***and*** booster

Hepatitis B
- positive HBsAb titer required; proof of vaccination alone not sufficient

Influenza
- Date of annual vaccine
- Must receive annually

MMR
- positive IgG titer required; proof of vaccination alone not sufficient

Tdap
- current tetanus, diphtheria, acellular vaccine within 10 years

Tuberculosis
- IGRA (QuantiFERON) ***preferred*** *or* two-step TB skin test
- If either test is positive, chest X-ray is required

Varicella
- Dates of vaccination (28 days apart) ***or***
- positive IgG titer

Student Acknowledgement

By signing below I, _____, acknowledge the following:

- A completed health form including documentation of immunization status and associated blood work must be completed before I can participate in class or clinical experiences.
- If my health status should change while I am a student in the practical nursing program, I must notify the program director to determine if additional clearance is needed.

Signature:_____ **Date:**_____

Name (printed):_____

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Student Information:

Name: _____ **DOB** _____
Last First M.I. MM/DD/YY

Address: _____
Street Apt/Unit #

_____
City State Zip Code

Contact: _____
Phone e-mail

Emergency Contact: _____
Name Relationship to Student

_____
Phone

Physical Exam Form – All Fields Required (*This section to be completed by health care provider*)

Date of Exam: _____

Allergies:

Does the student report or have a history of a latex allergy? ☐ Yes ☐ No

Does the student report or have a history of any other allergies? ☐ Yes ☐ No

If yes, please specify: _____

Does the student carry an Epi-pen? ☐ Yes ☐ No

Clearance for N95 Fit Testing (*per OSHA guidelines, N95 fit testing requires medical clearance*) ☐ **Yes** ☐ **No**

Student is medically cleared to be fitted for an N95 or other respirator & to wear it while caring for patients. The Griffin Hospital School of Allied Health Careers will arrange fit testing if needed for program of study.

Attestation of Student's Ability to Participate in Clinical Experiences

Per my physical exam and review of health history, it is my opinion that this student is able to participate in clinical activities with the exception of any limitations as noted below.

☐ **Yes** ☐ **No**

Limitations: _____

Provider Signature: _____ **Date:** _____ **Phone:** _____

Provider Name (printed): _____ **Office Address:** _____

Credentials: ☐ **MD** ☐ **DO** ☐ **PA** ☐ **APRN** _____

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Documentation of Evidence of Immunity – to be completed by healthcare provider

Student Name:_____ **DOB:**_____

Documentation of evidence of vaccine administration must be provided for all vaccines listed below. Documentation of titers required where indicated:

- **COVID-19** – Documentation of completed primary vaccine series ***and*** 1st booster

  Manufacturer: _____ Lot #:_____ Date:_____

  Manufacturer: _____ Lot #:_____ Date:_____

  Manufacturer: _____ Lot #:_____ Date:_____

  Manufacturer: _____ Lot #:_____ Date:_____

- **Hepatitis B** – dates of immunization & HBsAb titer required

  Dose 1: ___/___/___

  Dose 2: ___/___/___ (one month after dose 1)

  Dose 3: ___/___/___ (5 months after dose 2)

  Titer Results (at least 1-2 months after final dose with required lab report attached)

  ☐ Positive
  ☐ Negative

- **Influenza** – documentation of seasonal flu vaccine

  Manufacturer: _____ Lot #:_____ Date:_____

- **MMR** – dates of immunization & positive IgG titer required

  Dose 1: ___/___/___

  Dose 2: ___/___/___ (4 weeks after dose 1)

  Titer Results (with lab report attached)

  ☐ Positive
  ☐ Negative

- **Tdap** – current tetanus, diphtheria, acellular vaccine within 10 years

  Tdap dose: ___/___/___ (< 10 years)

- **Tuberculosis** – Two-step TB skin test ***or*** IGRA (QuantiFERON); If either is positive, chest X-ray required

  TB Blood Test (IGRA, i.e. QuantiFERON) ***preferred***

  Date of Blood Draw: ___/___/___

  Result: ☐ Positive ☐ Negative

  TB Skin Test (must be 2-step)

  Test #1: Date Placed: ___/___/___

  Date Read: ___/___/___ Result:_____

  Test #2: Date Placed: ___/___/___

  Date Read: ___/___/___ Result:_____

  **If either TB test is positive, chest x-ray required, with lab report attached

  Date of X-ray: ___/___/___ Result: ☐ Positive ☐ Negative

- **Varicella** – dates of vaccination (28 days apart) ***or*** positive IgG titer

  Dose 1: ___/___/___

  Dose 2: ___/___/___ (28 days after dose 1)

  Titer Results (with lab report attached)

  ☐ Positive ☐ Negative