



SOUTHSIDE REGIONAL MEDICAL CENTER PROFESSIONAL SCHOOLS provides educational opportunities without regard to race, color, religion, sex, age, disability, national origin, veteran status, sexual orientation, or any other status or condition protected by applicable laws, provided that an individual's qualifications meet the essential functions and criteria established for health sciences students, with or without reasonable accommodations..

Southside Regional Medical Center Professional Schools is and will continue to be in compliance with local, state, and federal laws including the Drug Free Schools and Communities Act of 1989. The School seeks to provide an educational environment free of drugs and alcohol.

**REQUIRED DOCUMENTS**

We are pleased that you are applying for admission to Southside Regional Medical Center Professional Schools. Listed in the box to the right are the documents required to make your application complete. Please use this checklist to help you submit your application. We look forward to receiving your application and working with you throughout the admission process. Inquiries, completed applications, and all other required documents should be sent to:

Office of Admissions  
 SRMC Professional Schools  
 737 South Sycamore Street  
 Petersburg, Virginia 23803  
 866.338.7762 Toll Free  
 804.765.5937 Fax  
 www.srmconline.com

TERM (select one)  January  August

Application deadlines are September 1 (January admission) and May 1 (August admission)

Indicate the program and term in which you wish to be considered for admission:

PROGRAM (select one program)

- Nursing
  - Traditional
  - Distance Learning
- Radiation Sciences
- Diagnostic Medical Sonography

Have you previously applied for admission to any programs at the Professional Schools?  Yes  No

If yes, when? \_\_\_\_\_

Have you attended another school/program in the health sciences field?  Yes  No

If so, which school? \_\_\_\_\_

How did you hear about the SRMC Professional Schools?

- Web Site
  - TV/Radio
  - Flyer
  - Newspaper
  - Other
  - High School/College Counselor
  - Career/College Fair
  - Friend/Family
  - Former Graduate
  - "On-Hold" message at your local CHS hospital
- \_\_\_\_\_ (please explain)

- Application (With \$70 non-refundable application fee to include KeyTrain testing & remediation)
- SAT or ACT scores (If taken within the last 3 years)
- Official copy of high school transcript (Or GED documentation)
- TOEFL, if applicable
- Student Statement
- Core Performance Standards for Admission & Progression
- Official copy of college transcripts
- Professional/Academic Reference Letters (3) (List each college previously attended)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please print (in ink) or type all information.

**PERSONAL INFORMATION**

.....

\_\_\_\_\_  
FULL NAME (LAST, FIRST, MIDDLE INITIAL, OTHER LAST NAMES)

\_\_\_\_\_  
EMAIL ADDRESS

\_\_\_\_\_  
HOME ADDRESS (NUMBER AND STREET)

\_\_\_\_\_  
CITY, STATE, ZIP CODE

\_\_\_\_\_  
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
EMERGENCY CONTACT NAME

\_\_\_\_\_  
EMERGENCY CONTACT TELEPHONE NUMBER

\_\_\_\_\_  
ARE YOU A U.S. CITIZEN?

\_\_\_\_\_  
IF NO, COUNTRY OF CITIZENSHIP

YES     NO

\_\_\_\_\_  
ALIEN REGISTRATION NUMBER (IF APPLICABLE)

\_\_\_\_\_  
HAVE YOU EVER BEEN CONVICTED OF OR ARE YOU PRESENTLY UNDER INDICTMENT FOR ANY FELONY OR MISDEMEANOR OFFENSE OTHER THAN TRAFFIC VIOLATIONS?\* IF YES, PLEASE EXPLAIN IN AN ATTACHED LETTER.     YES     NO

**\* Information is subject to change 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.*

\_\_\_\_\_  
HAVE YOU EVER HELD A PROFESSIONAL LICENSE OR CERTIFICATE?    IF YES, WHAT TYPE?    TYPE    DATE    STATE

YES     NO

\_\_\_\_\_  
HAS THIS LICENSE EVER BEEN INVESTIGATED OR DISCIPLINED? IF YES, PLEASE EXPLAIN IN AN ATTACHED LETTER.

YES     NO

\_\_\_\_\_  
ARE YOU A LICENSED PRACTICAL NURSE?

\_\_\_\_\_  
IF YES, WHAT SCHOOL DID YOU ATTEND?

\_\_\_\_\_  
GRADUATION DATE:

YES     NO

\_\_\_\_\_  
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 THE EXAMINATION.

PRACTICAL NURSE    STATE \_\_\_\_\_     YES     NO    DATE(S) \_\_\_\_\_    PASSED     YES     NO  
 CERTIFIED NURSE AID    STATE \_\_\_\_\_     YES     NO    DATE(S) \_\_\_\_\_    PASSED     YES     NO

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HAVE YOUR LICENSES EVER BEEN?

VOLUNTARILY SURRENDERED TO ANY LICENSING AUTHORITY?     YES     NO

PLACED ON PROBATION?     YES     NO

SUSPENDED?     YES     NO

REVOKED?     YES     NO

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, PLEASE EXPLAIN IN DETAIL ON A SEPARATE PIECE OF PAPER AND ATTACH TO YOUR APPLICATION.

### HIGH SCHOOL HISTORY

Please request official transcripts from all schools attended.

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HIGH SCHOOL LAST ATTENDED

CITY/STATE

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DATE OF GRADUATION

DATE OF GED OR EQUIVALENT (IF APPLICABLE)

### POST-SECONDARY EDUCATION

Please request official transcripts from all schools attended.

(LIST ALL FORMAL EDUCATION BEYOND HIGH SCHOOL IN CHRONOLOGICAL ORDER)

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NAME OF SCHOOL

CITY/STATE

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DATES ATTENDED (MONTH/YEAR TO MONTH/YEAR)

---

DEGREE/CREDITS RECEIVED:

DATE OF GRADUATION

---

NAME OF SCHOOL

CITY/STATE

---

DATES ATTENDED (MONTH/YEAR TO MONTH/YEAR)

---

DEGREE/CREDITS RECEIVED:

DATE OF GRADUATION

**POST-SECONDARY EDUCATION (CONT.)**

.....

---

NAME OF SCHOOL

CITY/STATE

---

DATES ATTENDED (MONTH/YEAR TO MONTH/YEAR)

---

DEGREE/CREDITS RECEIVED:

DATE OF GRADUATION

---

NAME OF SCHOOL

CITY/STATE

---

DATES ATTENDED (MONTH/YEAR TO MONTH/YEAR)

---

DEGREE/CREDITS RECEIVED:

DATE OF GRADUATION

**EMPLOYMENT INFORMATION**

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PLEASE LIST EMPLOYMENT HISTORY IN CHRONOLOGICAL ORDER. BEGIN WITH PRESENT EMPLOYMENT. (ATTACH ADDITIONAL SHEETS, IF NECESSARY.)

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NAME OF COMPANY/INSTITUTION

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STREET ADDRESS

---

CITY/STATE/ZIP

(AREA CODE) PHONE NUMBER

---

IMMEDIATE SUPERVISOR/NAME AND TITLE

---

POSITION HELD

MONTH/YEAR TO MONTH/YEAR

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REASON FOR LEAVING:

**EMPLOYMENT INFORMATION (CONT.)**

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---

NAME OF COMPANY/INSTITUTION

---

STREET ADDRESS

---

CITY/STATE/ZIP

---

(AREA CODE) PHONE NUMBER

---

IMMEDIATE SUPERVISOR/NAME AND TITLE

---

POSITION HELD

---

MONTH/YEAR TO MONTH/YEAR

---

REASON FOR LEAVING:

---

NAME OF COMPANY/INSTITUTION

---

STREET ADDRESS

---

CITY/STATE/ZIP

---

(AREA CODE) PHONE NUMBER

---

IMMEDIATE SUPERVISOR/NAME AND TITLE

---

POSITION HELD

---

MONTH/YEAR TO MONTH/YEAR

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REASON FOR LEAVING:

**May we contact your past and present employers?**

YES

NO

*If no, please explain in an attached letter.*

# NURSING APPLICANTS ONLY

## CORE PERFORMANCE STANDARDS FOR ADMISSION AND PROGRESSION

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Regulations Governing the Practice of Nursing, Code of Virginia (July 1, 2005) defines professional nursing as:

“the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board; or in the administration of medications and treatments as prescribed by any person authorized by law to preprescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgement, and skill based upon knowledge and application of principles from the biological, physical social, behavioral and nursing sciences.”

This practice of nursing involves cognitive, sensory, affective, and psychomotor performance requirements. Therefore, the essential eligible requirements for participation in a nursing program shall be further defined according to the following:

ISSUE	STANDARD	EXAMPLES OF NECESSARY ACTIVITIES
CRITICAL THINKING	Critical thinking ability for clinical judgement	Identify cause-effect relationships in clinical situations, develop nursing care plans
INTERPERSONAL	Interpersonal abilities sufficient for interaction with individuals, families and groups from various social, emotional, cultural and intellectual backgrounds	Establish rapport with patients/clients and colleagues
COMMUNICATION IN ENGLISH	Communication abilities sufficient for verbal and written interaction with others	Explain treatment procedures, initiate health teaching, and document and interpret nursing actions and patient/clients
MOBILITY	Physical abilities sufficient for movement from room to room and in small spaces	Move around in a patients’s room, work spaces and treatment areas; administer cardiopulmonary procedures
MOTOR SKILLS	Gross and fine motor abilities sufficient for providing safe, effective nursing care	Calibrate and use equipment; position patients/clients
HEARING	Auditory ability sufficient for monitoring and assessing health needs	Hear monitor alarm, emergency signals, auscultatory sounds and cries for help
VISUAL	Visual ability sufficient for observation and assessment necessary in nursing care	Observe patients/client responses
TACTILE	Tactile ability sufficient for physical assessment	Perform palpation, functions of physical examination and/or those related to therapeutic intervention (such as insertion of a catheter)

**NOTE:**

*Clinical experience is NOT observational. The list of necessary activities above is a sampling and not all inclusive. There may be more stringent requirements for clinical agencies that may preclude the student’s progression in the nursing program.*

I have read the Core performance Standards for Admission and Progression and hereby represent that I can effectively and safely perform the competencies listed.

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APPLICANT’S SIGNATURE

# ALL APPLICANTS

## DRUG SCREEN AND CRIMINAL BACKGROUND CHECK

Applicants who are accepted into a program are required to take a urine drug screen and undergo a criminal background check prior to the first day of class. Applicants who refuse to offer this information will be denied entry into the program. Testing positive on the drug screen may disqualify a student from being admitted into a program. In addition, certain criminal activity may also disqualify a student from clinical participation. Failure to participate in clinical activity will result in students not being able to achieve the course outcomes, resulting in failure of the course and dismissal from a program.

Students will also be expected to submit to random drug testing required by clinical sites.

In order to practice nursing, a student must obtain a license by applying for, taking and passing the National Council Licensure Exam for Registered Nurses (NCLEX-RN). Completion of course work and/or graduation from the program does not guarantee the student will be eligible to take the NCLEX-RN. Students who may have questions regarding the criminal background check need to contact an admissions officer in Student Services for further information.

I UNDERSTAND THE REQUIREMENTS OF THE DRUG SCREEN AND CRIMINAL BACKGROUND CHECK AND WILL COMPLY.

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APPLICANT'S SIGNATURE

## STATE REGULATIONS ON LICENSURE

The practice of nursing is regulated by state laws. Questions concerning licensure in a specific state should be directed to that state's Board of Nursing. Applicants for nursing licensure in Virginia are required to notify the State Board of Nursing if they have:

- Been convicted of (or pled Nolo Contendere) to the violation of any federal or state law.
- Been hospitalized or received treatment for chemical dependency preceding application to complete the licensing examination.
- A mental or physical condition which could interfere with their ability to practice nursing.

# ALL APPLICANTS

## 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 SRMC Professional Schools, 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 SRMC Professional Schools 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 the SRMC Professional Schools 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.

1. "Credit" assigned to nursing courses does not constitute "college credit" and does not imply nursing courses earn the equivalent of college credit.
2. The term "credit" assigned to nursing courses is for grading and/or financial purposes only; and
3. Only an authorized degree-granting institution in which a student enrolls may determine whether the completed nursing courses may be accepted for "college credit".

I, \_\_\_\_\_, have read and understand the statement  
(PRINT NAME HERE)  
regarding credits in the catalog from Southside Regional Medical Center Professional Schools.

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APPLICANT'S SIGNATURE

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PRINT NAME

DATE