

Select Term and Indicate Year:

Fall Semester _____ Spring Semester _____ Summer Semester _____

Applicant Information

Full Name: _____ Date: _____

Last First M.I.

Address: _____

Street Address Apartment/Unit #

City State ZIP Code

Phone: () E-mail Address: _____

Social Security No.:

Are you applying to the CNS program? YES NO Are you applying to the NP program? YES NO

Are you a resident of Nebraska? YES NO If yes, since when?

Are you a US Citizen? YES NO If no, list country of citizenship:

Classification? F-1 Visa J-1 Visa Immigrant Other _____

Desired Post-Master's Certificate

Track	Specialty Area(s)		
Adult Health and Illness	Adult <input type="checkbox"/>	Acute <input type="checkbox"/>	Oncology <input type="checkbox"/>
Family Nurse Practitioner		FNP <input type="checkbox"/>	FNP/Psych <input type="checkbox"/>
Gerontological			Gero <input type="checkbox"/>
Health Systems			Administration <input type="checkbox"/>
Psychiatric Mental Health			Psych <input type="checkbox"/>
Women's and Children's Health	Children's <input type="checkbox"/>	Women's Health <input type="checkbox"/>	
Education			Educator <input type="checkbox"/>

Educational History

(Chronological order of all Colleges or Professional Schools attended)

College Name and Address:

From: _____ To: _____ Did you graduate? YES NO Degree: _____

College Name and Address:

From: _____ To: _____ Did you graduate? YES NO Degree: _____

College Name and Address:

From: _____ To: _____ Did you graduate? YES NO Degree: _____

College Name and Address:

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Employment History
(Reverse Chronological Order *Most recent first)

Company: _____ Phone: () _____
Address: _____ Supervisor: _____
Job Title: _____
Responsibilities: _____
From: _____ To: _____

Company: _____ Phone: () _____
Address: _____ Supervisor: _____
Job Title: _____
Responsibilities: _____
From: _____ To: _____

Company: _____ Phone: () _____
Address: _____ Supervisor: _____
Job Title: _____
Responsibilities: _____
From: _____ To: _____

Required Supplemental Materials

1. Two Letters of Recommendation
2. All BSN and MSN Official Transcripts
3. Biographical Narrative in which describes your career goals and how a certificate in the requested program would aid in achieving these goals must be submitted. Use the space provided on the last page of the application or attach a separate document.
4. Disclosure Statement
5. \$45.00 Application Fee
6. Send your completed application and ALL materials to: UNMC, Graduate Studies
987810 Nebraska Medical Center
Omaha, NE 68198-7810

Signature: _____ Date: _____

Biographical Narrative:

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER
GRADUATE STUDIES

LETTER IN SUPPORT OF APPLICATION FOR ADMISSION TO GRADUATE STUDIES

It is the policy of the UNMC Graduate Studies Program to destroy letters of recommendation once an applicant has been admitted to the program. The Family Educational Rights and Privacy Act precludes examination of admission files (including letters of recommendation) by applicants.

Name of Applicant _____ Degree Sought _____

Field of Study _____ Specialty _____

To the respondent: The individual named above has applied for admission to one of the programs of graduate study at the University of Nebraska Medical Center. Your letter of support will help with our evaluation. We are particularly interested in your opinion of the applicant's ability to conduct advanced study and independent research, the applicant's general character, and capacity to pursue a successful career in his/her field.

I believe the applicant's ability to pursue graduate study in the field indicated is:

poor fair good superior uncertain

Signature _____ Date _____

Type or Print Name _____ Institution _____

Position _____ Address _____

Please send the completed form and one photocopy to the Graduate Studies Office, University of Nebraska Medical Center, 987810 Nebraska Medical Center, Omaha, NE 68198-7810. Thank you.

**UNIVERSITY OF NEBRASKA MEDICAL CENTER
DISCLOSURE STATEMENT**

Completion of this agreement is a formal part of the application process. This form must be completed and submitted before any offer of admission can be made. The University of Nebraska Medical Center reserves the right to verify this information with the appropriate law enforcement agencies. A positive response to any of the questions will not necessarily result in denial of admission. Information on this form **WILL NOT** be available to those persons evaluating your application for admission.

Have you ever:

- | | | | |
|----|--|-----|----|
| 1. | Had a health care license canceled, limited, suspended, revoked or denied? | YES | NO |
| 2. | Been subject to proceedings by a licensing agency to cancel, limit, suspend or revoke a license? | YES | NO |
| 3. | Been convicted of any criminal offense (including felonies and misdemeanors) other than a minor traffic violation or been the defendant in a civil suit? | YES | NO |
| 4. | Been given a dishonorable discharge from the U.S. Military? | YES | NO |
| 5. | Are you currently using alcohol or controlled substances that would affect your ability to participate in an academic program? | YES | NO |

FOR ANY YES RESPONSES, PLEASE APPEND DETAILS ON A SEPARATE SHEET

I certify that information on this form is complete, accurate and true; and I understand that any information given falsely or withheld may make me ineligible for admission and/or enrollment.

Print AND sign your name

Date

Social Security Number

In evaluating conviction records, the University of Nebraska Medical Center considers the following factors:

1. The relationship of the conviction to the program to which you are being considered for admission.
2. Circumstances surrounding the conviction
3. The time interval from the conviction to application
4. Other relevant history
5. Rehabilitation