

PRACTICAL NURSING PROGRAM APPLICATION PACKET

Name of Applicant *(Please Print)* _____

Please complete this form and return it to the Admissions Office with all of the requirements. The following items must be completed and submitted in an enclosed envelope to be considered for admission to the Practical Nursing Program. The application deadline is November 20, 2007 by 5:00pm.

APPLICATION CHECKLIST:

Nurse Entrance Test (NET) Result

The minimum requirement is a composite score of at least 70% and scores of at least 70% in both math and reading comprehension.

- Check this box if you took the NET at MPI. The Admissions Office retains the original result and you will **NOT** need to submit a copy to us.
- Check this box if you took the NET at another location within the past year. MPI requires that we receive a copy directly from Educational Resources Inc. (ERI). Please contact ERI and have them mail results to:
PN Admissions, Medical Professional Institute (MPI), 388 Pleasant Street, Suite 305, Malden, MA 02148

Application Form and personal statement

Application fee of \$50. *(Checks payable to MPI)*

Resume

Diploma and transcripts:

- Copy of high school diploma or equivalent (GED) including transcripts (if received outside of the United States, diploma and transcript must be submitted with an official translation into English).
- Students may submit official college transcripts for review to receive transfer credit for course work successfully completed with a "C" or better.

Three letters of references/recommendations:

Completed reference forms must be received in sealed envelopes signed by the person serving as reference. MPI will not accept reference forms received in opened or tampered envelopes.

Proof of Health Insurance (Provide copy of front and back of the insurance card)

Current CPR certification. (Provide copy of front and back of the CPR card)

Call MPI or check the website for schedule of CPR courses

Criminal Offender Record Information (CORI) check permission form.

IMPORTANT!

Some clinical agencies prohibit clinical participation based on a conviction in a court of law. This will then not allow successful completion of the program. In addition, all applicants for licensure as RN or LPN must be of "good moral character" as required by the Massachusetts Board of Registration in Nursing. Court record/past conviction may present a barrier to eligibility for licensure as a registered nurse (RN) or as a licensed practical nurse (LPN). The Board of Registration in Nursing's "good moral character" requirement can be found online at www.state.ma.us/reg/boards/rn/

Please note that CORI checks will not be run until after you have been accepted in the program.

Explanation of Medical Records Form with Student's Attestation

Medical Records Form (optional for this step but required after you have been selected for admissions)

A recent physical examination record from a medical doctor stating the physical capability of the applicant to perform the tasks of a health care provider, including immunizations required by the Massachusetts Department of Health

SUBMIT THIS FORM WITH THE COMPLETED ADMISSION REQUIREMENTS BY MAIL OR IN PERSON TO MEDICAL PROFESSIONAL INSTITUTE, 388 PLEASANT STREET, SUITE 305, MALDEN, MA 02148

Signature of Applicant

Date



388 Pleasant St., Ste. 305
Malden, MA 02148

Medical Professional Institute

Application for Practical Nursing Program

Tel: (781) 397-6822
Fax: (781) 397-8811
Institute@mpi.edu
www.mpi.edu

You may attach a resume, but please complete this application as well by printing in ink or typing.

Medical Professional Institute is an equal opportunity school, and does not discriminate on the basis of race, religion, national origin, sex, age, handicap, marital status, or status as a disabled veteran. Information provided on this application will not be used for any discriminatory purpose. Please provide any other names used on any of your educational or employment records if they differ from that written below.

Last name	First	MI	Social Security Number	Date of Birth	Age
Street Address			Home Telephone	Work Telephone	
City	State	Zip	Alternative Telephone	Date of Application	

Are you a U.S. citizen? Yes No Are you authorized to work in the U.S.? Yes No Visa Type: _____

Ethnic Origin (Optional - Statistical Purposes Only):
 Asian/Pacific Islander Black (Not Hispanic) Hispanic American Indian/Alaskan Native White (Not Hispanic)

Time of Class Preferred: Schedule 1: 3 mornings (within 8-2) and 2 evenings (within 5-10pm)
 Schedule 2: 4 evenings (within 4-10pm) and every other Saturday (8am-5pm)

Have you ever applied at Medical Professional Institute before? _____ How were you referred to Medical Professional Institute? _____

Means of Transportation: Car Public Transportation Both E-mail Address: _____

PROFESSIONAL LICENSES (Do NOT include your driver's license)

Type: _____ Reg.#: _____ Expires: _____ State: _____

RESOURCES FOR TUITION: Explain your resources for tuition

If your tuition will be provided by another person, please provide his/her name, address, and telephone number, his/her relationship to you, and a signed statement from the person indicating that he/she will assume the responsibility of paying the total amount of the tuition.

Name: _____ Relationship: _____
 Address: _____ Telephone # _____

(Please enclose the signed statement.)

EMERGENCY CONTACT INFORMATION

Please state who Medical Professional Institute should contact in case of an emergency.

Name: _____ Relationship: _____
 Address: _____ Telephone # _____

EDUCATIONAL HISTORY

School Name and Location (City, State)	Major Course or Subject	Dates Attended		Graduated		Degree
		From	To	Yes	No	
High School						
College/Technical School						
Other Education/Training						

MEDICAL PROFESSIONAL INSTITUTE PRACTICAL NURSING PROGRAM

EXPLANATION OF MEDICAL RECORDS FORM

The following is an explanation of the required medical/immunization/vaccination records needed for you to start/continue the program:

1. Proof (including date) of a physical examination performed by a physician, nurse practitioner, or physicians assistant within the last year (1 year) prior to students start date stating that the student is physically and mentally able to start/continue the program, is free from communicable diseases and is in good health
2. Proof (including date) of Measles, Mumps, Rubella vaccination or immunity within the last ten (10) years from the students start date
3. History of Varicella (chicken pox) by a physician or a positive Varicella antibody titer or a history of two (2) Varicella vaccine doses
4. Proof (including date) of Hepatitis B vaccination series or a positive Hepatitis B surface antibody titer within the last ten (10) years from the students start date
5. Date and result of a PPD test within the last year (1 year) of the student's start date or for those students with a history of a positive PPD test a chest x-ray within the last year (1 year) of the student's start date
6. Proof of Tetanus/Diphtheria vaccination within the last ten (10) years from the students start

After you have been selected for admissions, you will be required to sign a statement of general health (separate form) and have your physician sign a medical records form.

Persons accepted into the Practical Nursing program should be physically and mentally sound. For student and patient safety concerns, the student must be able to:

- Stand for a minimum of 4 hours
- Walk for a minimum of 6 hours
- Heavy lifting up to 40 pounds
- Straight pulling and pushing for a minimum of 2 hours
- Stoop, bend and repeated squatting for a minimum of 30 minutes
- Finger dexterity
- Both hands and legs required or compensated by the use of acceptable prostheses
- Climb stairs, legs only (1-2 hours/shift)
- Ability for rapid mental and muscular coordination simultaneously
- Normal or acceptable corrected visual and auditory acuity
- Process and respond to written and verbal instructions
- Perform multiple tasks simultaneously
- Communicate effectively with others
- Remain calm, rational, decisive, and in control at all times, especially during emergency
- Function without causing harm to self or others

I, _____ (*print name*), understand that it is essential for Nursing students to be able to perform a number of physical activities in the clinical portion of the program and that I have given careful consideration to the mental and physical demands of the program prior to making this application.

Signature of Applicant

Date



Medical Professional Institute

388 Pleasant Street, Malden, MA 02148
Tel: (781) 397-6822 Fax: (781) 397-8811
www.mpi.edu

Medical Record Release Form

Dear Student/Applicant:

Please have your physician complete this form and return it to our office promptly.

_____ is in good health and free from any infectious
(Student's name)

diseases or conditions which are incompatible with the performance of his/her occupation.

Date of last physical examination: _____

Has the applicant received, or is the applicant receiving, treatment for any medical and/or emotional problems? Yes___ No___ (If yes, please comment (specify):

Please list all medications regularly used:

Date and immunity status of last vaccine for:

Rubella: _____ Measles: _____

Mumps: _____ Chicken Pox: _____

Hepatitis B: _____ Titer: _____

PPD Test: _____ Result: _____

Chest X-Ray: _____ Result: _____

Tetanus: _____ Diphtheria: _____

Today's Date: _____

Physician's Signature: _____

Physician's Name: _____

Physician's Address: _____

Telephone Number: _____

Please return this form to Medical Professional Institute. Thank you in advance for your cooperation.

MEDICAL PROFESSIONAL INSTITUTE - PRACTICAL NURSING PROGRAM

REFERENCE FORM (1)

This section to be completed by the applicant:

<i>Applicant's Last Name</i>	<i>Applicant's First Name:</i>
<i>Name of Evaluator/Reference:</i>	<i>Affiliation:</i>
<i>Under the provisions of the Family Educational Rights and Privacy Act of 1974, I waive my right of access to this reference form; Medical Professional Institute may consider it confidential.</i>	
_____	_____
<i>Signature of Applicant</i>	<i>Date</i>

This section to be completed by the evaluator:

The applicant named above has applied for admissions to the Practical Nursing program at Medical Professional Institute and has listed you as a reference. Please complete this form and send it back to the applicant in a sealed and signed envelope. We assure you that any information given to us will be held in the strictest confidentiality. Thank you for your assistance.

How long and in what capacity have you known this applicant?

Please carefully assess the applicant in the following areas:

	Excellent	Very Good	Good	Fair	Poor	Unable to Evaluate
Dependability and Reliability						
Flexibility						
Initiative						
Leadership						
Motivation						
Oral Communication Skills						
Written Communication Skills						
Interpersonal Skills						
Professionalism and Work Ethics						
Judgment and Critical Thinking						
Emotional Maturity						
General Academic Ability						

Strengths: _____

Weakness: _____

Would you recommend this applicant for this program? Yes ___ No ___ If "No" Why? _____
 Please feel free to use the reverse side for any additional comments.

Name of Reference: _____ Title: _____

Signature: _____ Date: _____

MEDICAL PROFESSIONAL INSTITUTE - PRACTICAL NURSING PROGRAM

REFERENCE FORM (2)

This section to be completed by the applicant:

<i>Applicant's Last Name</i>	<i>Applicant's First Name:</i>
<i>Name of Evaluator/Reference:</i>	<i>Affiliation:</i>
<i>Under the provisions of the Family Educational Rights and Privacy Act of 1974, I waive my right of access to this reference form; Medical Professional Institute may consider it confidential.</i>	
_____	_____
<i>Signature of Applicant</i>	<i>Date</i>

This section to be completed by the evaluator:

The applicant named above has applied for admissions to the Practical Nursing program at Medical Professional Institute and has listed you as a reference. Please complete this form and send it back to the applicant in a sealed and signed envelope. We assure you that any information given to us will be held in the strictest confidentiality. Thank you for your assistance.

How long and in what capacity have you known this applicant?

Please carefully assess the applicant in the following areas:

	Excellent	Very Good	Good	Fair	Poor	Unable to Evaluate
Dependability and Reliability						
Flexibility						
Initiative						
Leadership						
Motivation						
Oral Communication Skills						
Written Communication Skills						
Interpersonal Skills						
Professionalism and Work Ethics						
Judgment and Critical Thinking						
Emotional Maturity						
General Academic Ability						

Strengths: _____

Weakness: _____

Would you recommend this applicant for this program? Yes ___ No ___ If "No" Why? _____

Please feel free to use the reverse side for any additional comments.

Name of Reference: _____ Title: _____

Signature: _____ Date: _____

MEDICAL PROFESSIONAL INSTITUTE - PRACTICAL NURSING PROGRAM

REFERENCE FORM (3)

This section to be completed by the applicant:

<i>Applicant's Last Name</i>	<i>Applicant's First Name:</i>
<i>Name of Evaluator/Reference:</i>	<i>Affiliation:</i>
<i>Under the provisions of the Family Educational Rights and Privacy Act of 1974, I waive my right of access to this reference form; Medical Professional Institute may consider it confidential.</i>	
_____	_____
<i>Signature of Applicant</i>	<i>Date</i>

This section to be completed by the evaluator:

The applicant named above has applied for admissions to the Practical Nursing program at Medical Professional Institute and has listed you as a reference. Please complete this form and send it back to the applicant in a sealed and signed envelope. We assure you that any information given to us will be held in the strictest confidentiality. Thank you for your assistance.

How long and in what capacity have you known this applicant?

Please carefully assess the applicant in the following areas:

	Excellent	Very Good	Good	Fair	Poor	Unable to Evaluate
Dependability and Reliability						
Flexibility						
Initiative						
Leadership						
Motivation						
Oral Communication Skills						
Written Communication Skills						
Interpersonal Skills						
Professionalism and Work Ethics						
Judgment and Critical Thinking						
Emotional Maturity						
General Academic Ability						

Strengths: _____

Weakness: _____

Would you recommend this applicant for this program? Yes ___ No ___ If "No" Why? _____

Please feel free to use the reverse side for any additional comments.

Name of Reference: _____ Title: _____

Signature: _____ Date: _____



Medical Professional Institute

388 Pleasant Street, Suite 305, Malden, MA 02148
(781) 397-6822 Fax: (781) 397-8811

XMDPRF
CH444
§

CORI REQUEST FORM

Medical Professional Services, Inc. d/b/a Medical Professional Institute has been certified by the Criminal History Systems Board for access to all the available criminal offender record information on the following individual from the Criminal History Systems Board pursuant to Chapter 6 § 172C that mandates agencies which employ or accept as a volunteer or refer for employment any individual who will provide care, treatment, education, training, transportation, delivery of meals, instruction, counseling, supervision, recreation or other services in a home or in a community based setting for any elderly person or disabled person or who will have any direct or indirect contact with such elderly person or disabled persons or access to such person's files shall obtain all available CORI from the Criminal History Systems Board prior to employing such individual, accepting such individual as a volunteer or referring such individual for employment.

APPLICANT/EMPLOYEE INFORMATION (PLEASE SIGN)

PLEASE PRINT:

LAST NAME

FIRST NAME

MIDDLE NAME

MAIDEN NAME OR ALIAS (IF APPLICABLE)

PLACE OF BIRTH

DATE OF BIRTH

____ - ____ - ____
SOCIAL SECURITY NUMBER

MOTHER'S MAIDEN NAME

FORMER ADDRESSES: _____

SEX: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____ EYE COLOR: _____

STATE DRIVER'S LICENSE NUMBER: _____

***THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: _____

DO NOT WRITE BELOW THIS LINE

REQUESTED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE