

Learner Application Checklist

Your Full Name: _____ Maiden Name: _____

Please mail this completed checklist with items listed as *"Mail with Completed Checklist"* to:

webWOC Nursing Education Program- Admissions
2800 University Ave. SE, Suite 100
Minneapolis, MN 55414

Learner Application

- I have submitted my application online at webWOCnurse.com.
 - My date of birth (MM/DD/YYYY) is: _____ / _____ / _____.
 - The last four digits of my Social Security Number* are: XXX - XX - _____.
- *Used to retrieve your background check.

Application Fees - *Mail with Completed Checklist*

- I have included a \$20 non-refundable application fee made payable to Metropolitan State University.
- I have included a \$75 non-refundable application fee made payable to webWOC Nursing Education Program.

Reference Request Forms - *Mail with Completed Checklist*

Required: You must use the Reference Request Forms on page 2-3 of this document.

- I have included a copy of an Employer/Supervisor completed Reference Request Form.
- I have included a copy of a Co-worker/Professional Colleague completed Reference Request Form.

Requested Official Transcripts for all undergraduate/ graduate work*.

**Required: Original transcripts must be requested from EACH institution offering credits toward your degree (transfer credits).
Exception: If you have a Master's in Nursing, only request a transcript from the institution that awarded your master's degree.*

For your convenience, you will find a Request for Official Transcripts Form on page 4 of this document.

- I have requested transcripts from _____ for my _____.
- College/University Name Degree Earned
- I have requested transcripts from _____ for my _____.
- College/University Name Degree Earned
- I have requested transcripts from _____ for my _____.
- College/University Name Degree Earned

Supporting Documentation - *Mail with Completed Checklist*

- I submitted my RN License Verification information with my online application
OR I have included a completed Notarized Verification of RN Licensure Form (page 5 of this document).
- I have included a copy of my Malpractice insurance.
- I have included a copy of my HIPAA training.
- I have included a copy of my CPR certification.
- I have included a copy of my current Mantoux (TB) skin test.
- I have included a copy of my Hepatitis B Vaccination.

Background Check - *Mail with Completed Checklist*

Steps to complete:

1. Contact Certified Background at <http://www.certifiedbackground.com>
2. Proceed to "Applicants" and enter our code: WE47
3. You will receive an e-mail response from Certified Background with a code for the results.

- The background check code provided to me by Certified Background is: _____.



Reference Request (Peer/Coworker)



webWOC Nursing Education Program (a program offered in collaboration with Metropolitan State University)

Applicant's Name _____ () - _____ / /
Applicant's Phone Number _____ Today's Date

Instructions: The person named above has applied for admission to the webWOC Nursing Education Program in the College of Nursing and Health Sciences at Metropolitan State University. The Admissions Committee would appreciate your assessment of the applicant. If you are unable to assess the applicant in more than half of the categories listed below, please contact the applicant so that she/he can request a recommendation from someone who is able to assess her/him in a majority of the categories listed.

Required: References must be submitted on this form to be accepted. Separate letters of recommendation will not be reviewed. To add general comments (i.e. strengths and potential weaknesses of the applicant, initiative, motivation, etc.), please use the opposite side of this form.

Evaluator's Name _____ Position/Title _____ () -
Phone Number _____

1. My relationship to the applicant is:

- Employer/Supervisor
- Former Faculty/Instructor
- Co-worker/ Professional Colleague

2. I have known the applicant for _____ years and _____ months.

3. From among the college/professional nurse population with whom you are acquainted, how would you rate this applicant? (Please mark checkboxes below as appropriate)

	Superior (top 15%)	Very Good (top 33%)	Satisfactory (top 50%)	Un- satisfactory	Unable to Evaluate
Clinical Nursing Competence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diligence and Perseverance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leadership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teaching Ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you recommend the applicant for this program?

- Yes
- No

Evaluator's Signature _____ Date _____ / /

Please mail this completed form to [webWOC Nursing Education Program, 2800 University Ave. SE, Suite 100, Minneapolis, MN 55414](#) OR Fax to 612-379-9263.

Questions? Call (612) 331 - 4601 or email partners@webwocnurse.com



Reference Request (Supervisor)



webWOC Nursing Education Program (a program offered in collaboration with Metropolitan State University)

Applicant's Name _____ () - _____ / / Today's Date
Applicant's Phone Number

Instructions: The person named above has applied for admission to the webWOC Nursing Education Program in the College of Nursing and Health Sciences at Metropolitan State University. The Admissions Committee would appreciate your assessment of the applicant. If you are unable to assess the applicant in more than half of the categories listed below, please contact the applicant so that she/he can request a recommendation from someone who is able to assess her/him in a majority of the categories listed.

Required: References must be submitted on this form to be accepted. Separate letters of recommendation will not be reviewed. To add general comments (i.e. strengths and potential weaknesses of the applicant, initiative, motivation, etc.), please use the opposite side of this form.

Evaluator's Name _____ Position/Title _____ Phone Number () - _____

1. My relationship to the applicant is:

- Employer/Supervisor
- Former Faculty/Instructor
- Co-worker/ Professional Colleague

2. I have known the applicant for _____ years and _____ months.

3. From among the college/professional nurse population with whom you are acquainted, how would you rate this applicant? (Please mark checkboxes below as appropriate)

	Superior (top 15%)	Very Good (top 33%)	Satisfactory (top 50%)	Un- satisfactory	Unable to Evaluate
Clinical Nursing Competence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diligence and Perseverance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leadership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teaching Ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you recommend the applicant for this program?

- Yes
- No

Evaluator's Signature _____ Date _____ / /

Please mail this completed form to [webWOC Nursing Education Program, 2800 University Ave. SE, Suite 100, Minneapolis, MN 55414](#) OR Fax to 612-379-9263.

Questions? Call (612) 331 - 4601 or email partners@webwocnurse.com



Transcript Request



webWOC Nursing Education Program (a program offered in collaboration with Metropolitan State University)

To: Office of Student Records at _____
(insert school name)

Please send an official transcript to:

webWOC Nursing Education Program
2800 University Ave. SE, Suite 100
Minneapolis, MN 55414
(612) 331 - 4601
partners@webwocnurse.com

First Name Middle Initial Last Name Maiden Name

Student ID Number - - / / /
Social Security Number Date of Birth

Street Address

City State Zip Code Telephone Number

College (if appropriate)/ Major/ Program Dates of Attendance

Signature Date



Notarized Verification of RN Licensure



webWOC Nursing Education Program (a program offered in collaboration with Metropolitan State University)

In keeping with the position of the Minnesota State Board of Nursing, we ask that you submit notarized verification that your RN license is current rather than submitting a photocopy of your RN license. A Notary Public can be found in most hospitals, banks and libraries. **Please do not submit a photocopy of your RN license.**

Name of RN

Nursing License Number	Issuing State	License Expiration Date
		/ /
		/ /
		/ /
		/ /

Signature of RN

_____/_____/_____
Date

Notary Public: You are verifying that the person presenting their RN license to you is the person listed on the license, that the license does not appear to be altered in any fashion and that the information above concerning license number issuing state and expiration date accurately reflects what is provided on their license.

Signature of Notary Public

_____/_____/_____
Date

Confidential Student Information

Where life and learning meet.™



This information will be used for Metropolitan State University's compliance with required state and federal reports on enrollment, for evaluating student recruitment and retention policies, and for other university research and reporting purposes. **Providing this information is voluntary. Please submit this form (blank or completed) with your application checklist.**

First Name _____
Last Name _____
MI _____
For Office Use Only
Tech ID Number _____ / _____ / _____
Birth Date (MM/DD/YY)

Gender (circle one): **Have you served or are you currently serving in the U.S. military** (circle one)?
Male **Female** **Yes** **No**

Are you Hispanic or Latino (a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or Spanish Culture, regardless of race)?
Yes **No**

Race and ethnic background (please check all that apply):

- American Indian or Alaska Native** (a person having origins in any of the original peoples of North, Central or South America and who maintains tribal affiliation or community attachment.)
- Asian** (a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent.)
- Black or African American** (a person having origins in any of the black racial groups of Africa.)
- Native Hawaiian or Other Pacific Islander** (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- White** (a person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

What is the highest level of education for your parent(s)/guardian(s)? Please respond for the parent(s), step-parent(s), adoptive parent(s) or guardian(s) who raised you.

- | <u>Parent/Guardian #1</u> | <u>Parent/Guardian #2</u> |
|---|---|
| <input type="checkbox"/> No high school diploma | <input type="checkbox"/> No high school diploma |
| <input type="checkbox"/> High School diploma | <input type="checkbox"/> High School diploma |
| <input type="checkbox"/> Some college | <input type="checkbox"/> Some college |
| <input type="checkbox"/> Two-year college degree/diploma | <input type="checkbox"/> Two-year college degree/diploma |
| <input type="checkbox"/> Bachelor's Degree/higher | <input type="checkbox"/> Bachelor's Degree/higher |
| <input type="checkbox"/> Not Sure/ Don't know | <input type="checkbox"/> Not Sure/ Don't know |

If you need this document in an alternative format, please contact Disability Services at 651-793-1549.