# Learner Application Checklist

Your Full Name: _____ Maiden Name:_____

**You may use this checklist to keep track of the documents needed for your Learner Application**

**Online Learner Application**

- ☐ I have submitted my application online at webwocnurse.com.
- ☐ I have submitted my Resume either online at webwocnurse.com or via email at admissions@webwocnurse.com.

**Application Fees -** Click here for online payment

- ☐ I have paid my application fee online.

**Please send the below items to us via:**

Email: admissions@webwocnurse.com -OR- Fax: 612-926-8075 -OR-
Mail: WEB WOC Nursing Education Program, 200 Southdale Center, Minneapolis, MN 55435

**1 - Reference Request Forms**

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

- ☐ I have included a copy of an Employer/Supervisor or Former Faculty/Instructor completed Reference Request Form.
- ☐ I have included a copy of a Peer/Co-Worker or Professional Colleague completed Reference Request Form.

**2 - Submitted Official Transcripts (or Student issued copy) for all undergraduate/ graduate work*.**

** Required: Original transcripts from bachelor's degree and RN Degree*
*If you have an MSN, only request a transcript from the institution that awarded your masters degree*

** All Foreign transcripts (i.e., bachelor's/associate's) from degree-granting universities must be evaluated for verification of education, coursework and calculation of GPA. The evaluation must be a 'Course by Course' report from an organization such as: www.wes.org, www.ece.org, or www.cgfns.org (if using CGFNS, the evaluation is called an 'Academic Report').*

- ☐ 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
- ☐ I have requested an Academic Report of my foreign transcript for my_____.
  Degree Earned

**3 - Supporting Documentation -** *May be required for Clinical Practicum, but not for acceptance into program.*

- ☐ Malpractice insurance (current within one year). If you are covered by your employer and planning to do clinical practicum within your own facility, proof of coverage through your employer is sufficient (ie., copy of policy page).
- ☐ Current CPR certification card.
- ☐ Proof of Varicella
- ☐ Most recent Mantoux (TB) skin test or chest x-ray results.
- ☐ Hepatitis B Vaccination (titer results or signed declination is also sufficient).
- ☐ Influenza Vaccination documentation.

**4 - Background Check** *- A current background check may be required for Clinical Practicum (must be current within one year* **)**

- ☐ If you are a **Minnesota Resident**, you must complete a **DHS Background Study**:
  1. click here for instructions: https://webwocnurse.com/wp-content/uploads/2019/01/WEB-WOC_MN-Background-Check-Info.pdf
- ☐ Purchase a background check from **Castle Branch**: www.castlebranch.com
  1. Go to www.castlebranch.com
  2. Click on the button labeled "PLACE ORDER" enter our package code: WE47
  3. Follow instructions on screen to continue processing order
  4. You will receive an email response from Castle Branch confirming your order
  5. Once the background check is complete, WEB WOC will print on their end

WEB WOC Nursing Education Program
200 Southdale Center
Minneapolis, MN 55435
Phone: 612-331-4601 Fax: 612-926-8075
Email: admissions@webwocnurse.com

# Reference Request
# Employer/Supervisor or Former Faculty/Instructor

## WEB WOC Nursing Education Program

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

**Instructions:** The person named above has applied for admission to the WEB WOC Nursing Education Program. 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 Printed Name | Position/Title | Phone Number ( ) - |
|---|---|---|
| Evaluator's Employer | City/State | |

1. My relationship to the applicant is:

   ☐ Employer/Supervisor
   ☐ Former Faculty/Instructor

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 | | | | | |
| Integrity | | | | | |
| Diligence and Perseverance | | | | | |
| Oral Expression | | | | | |
| Ability to work with Others | | | | | |
| Flexibility | | | | | |
| Leadership | | | | | |
| Creativity | | | | | |
| Teaching Ability | | | | | |

4. Do you recommend the applicant for this program?

   ☐ Yes
   ☐ No

| Evaluator's Signature | Date / / |
|---|---|

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Mail: WEB WOC Nursing Education Program, 200 Southdale Center, Minneapolis, MN 55435

*Questions? Call 612-331-4601 or email us at: admissions@webwocnurse.com*

# Reference Request
# Peer/Co-Worker or Professional Colleague

## WEB WOC Nursing Education Program

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

**Instructions:** The person named above has applied for admission to the WEB WOC Nursing Education Program. 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 Printed Name _____ Position/Title _____ Phone Number ( ) - _____

Evaluator's Employer _____ City/State _____

1. I am a Peer/Co-Worker or Professional Colleague of the applicant.

   ☐ TRUE
   ☐ FALSE

2. I have known the applicant for_____years and_____months.

3. From among the 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 | | | | | |
| Integrity | | | | | |
| Diligence and Perseverance | | | | | |
| Oral Expression | | | | | |
| Ability to work with others | | | | | |
| Flexibility | | | | | |
| Leadership | | | | | |
| Creativity | | | | | |
| Teaching Ability | | | | | |

4. Do you recommend the applicant for this program?

   ☐ Yes
   ☐ No

Evaluator's Signature _____ Date / /

Please send this completed form to:

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