

**College of Nursing
University of Missouri-St. Louis**

**Master of Science in Nursing
Supplemental Application - Non-Practitioner**

Application Sought for:

Fall: ____ **Winter:** ____ **Year:** _____ **Full-time:** ____ **Part-time:** ____

Name: (Last) _____ (First) _____ (Middle/Birth) _____
(Print)

Address:

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Home:** _____ **Work:** _____

Social Security Number:

RN License: Number: _____ State and Exp. Date: _____

Has any disciplinary action been taken against your nursing license? YES ____ **NO** ____
If yes, please attach a letter of explanation.

BSN Education: Institution: _____ Year Graduated: _____

NLN/CCNE Accredited: YES _____ NO _____

Role Option: (Check one)

____ Nurse Leader ____ Nurse Educator

Undergraduate Grade Point Average: _____
(Official transcripts to be submitted to Graduate Admissions)

Statistics: Course Number: _____ Course Name: _____
Date completed: _____ Grade received: _____ Institution completed: _____

Health Assessment: Course Number: _____ Course Names: _____
Date completed: _____ Grade received: _____ Institution completed: _____
Free standing: _____ Integrated: _____

Clinical Experience in the past five years (Specifically within area you wish to study)

Agency	Dates Employed	Job Description and Hours per week

PLEASE RETURN WITH THIS FORM:

- A copy of your current RN License**
- A copy of your current CPR Certification**
- Completed copy of enclosed Immunization form**

UNIVERSITY OF MISSOURI-ST. LOUIS
College of Nursing

Immunization Form

Name: _____

Student #: _____ Clinical Track: _____

It is the College's policy that all students provide documentation of the following immunizations and/or testing **PRIOR** to initiating clinical activities:

Tuberculosis skin test within last 12 months Date:
(Must be repeated annually)

All positive reactors require chest x-ray Results:

Tetanus/diphtheria immunity within last 10 years Date:

If born after 1957:

MMR booster Date:

OR

Two doses of measles vaccine after age 12 Date:
Date:

OR

Evidence of immunity via titre Date:

Hepatitis B vaccine series recommended within Dates:
Past five years

First two injections 30 days apart Dose #1:

Dose #2:

Third injection six months later Dose #3: