South Florida Healthcare Institute Practical Nursing Application Packet

Program Description

South Florida Healthcare Institute Practical Nursing Program is designed to prepare students for successful passage of the NCLEX-PN and future employment as a Licensed Practical Nurse. Clinical experiences are included as an integral part of this program. The program is approved by the Florida State Board of Nursing and Florida Department of Education.

Program Details

Program Length: 1350 Hours (12 months full-time, 14 months part-time)
Delivery Method: Traditional - 100% classroom based

Program Hours

Days: Classroom: Monday – Wednesday 8:30 a.m. – 4:30 p.m. Clinical and Externship Hours: Vary
Nights: Classroom: Monday - Thursday, 5:30 p.m. – 10:30 p.m. Clinical and Externship Hours: Vary

Program Location

South Florida Healthcare Institute - 7700 West Camino Real, Suite 401, Boca Raton, FL 33433
Clinical rotations are included within each course for both day and evening programs (instructors will provide clinical schedules). Times and dates may vary.

General Requirements

Applicants seeking admission to the PN Program must:

• Be at least 18 years of age at projected time of program completion.

• Have a high school diploma or equivalent.

• Pass random drug screenings throughout the program. Students with positive drug screen results will be withdrawn from the program.

To apply for acceptance into the PN Program students must:

• Interview with Nursing Program Director and provide official transcripts for high school and college (if applicable). For copy of your GED transcript go to www.myged.com.

• Meet with Financial Aid. SFHI has partnered with Meritize, student loan company. Meritize looks beyond FICO scores and uses an individual's previous achievements to improve funding opportunities. Even students who may lack a co-borrower can improve their loan options by sharing academic transcripts, military experience and work history. (If you are self-pay, you may skip this step).

Complete the Practical Nursing Application Packet

The Practical Nursing application packet must include:

• Health education student information sheet

• Writing sample

• 1 letter of recommendation (professional recommendation preferred, if personal, it can not be from a family member)

• HESI test official results - submit with the application packet

• College transcripts for students who have earned an Associates Degree or beyond. Applicants who have earned an AA or more are exempt from taking the HESI entrance exam.

• Student school physical form and immunization record

• Electronic Finger Printing and receipt of payment. This is a Level 2 criminal background that is sent to the Florida Board of Nursing. This must be completed prior to submitting the application, at the student's expense. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear background.

• Copy of Basic Life Support certification through the American Heart Association or American Red Cross.

LATE OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

Testing Information

HESI Admission Assessment Exam

What Is The HESI® Admission Assessment (A2)? It is a standardized and proctored entrance exam completed by applicants of Nursing & Healthcare Education programs. The exam has been used for over 20 years to assess the academic readiness of prospective students for diverse programs.

The entrance exam for the Practical Nursing program includes the following:

- Reading Comprehension (including subsections)

The passing score on the HESI A2 entrance exam for the Practical Nursing program is a 70% cumulative score or higher in both sections. There is a $50.00 fee for this exam. Retests are $50. The HESI exam can be taken twice. Applicants must contact the Nursing Program director to register and pay for the HESI entrance exam. The examination is conducted at the school. For more information please contact 800-816-3489.

Health Requirements

Applicants are required to complete a school physical (not more than 12 months old), utilizing our school form and provide a copy of their immunization record. If, after acceptance, a student's health status changes, further documentation may be required stating the student is physically able to continue the program. A drug test will be required prior to clinical rotations. Students who do not pass the drug screening will be withdrawn from the program. Applicants are required to provide proof of the following current immunizations or titers:

- MMR x2
- Hepatitis B series X3 or Hepatitis B declination form
- Varicella x2
- Seasonal Flu Vaccine (August-March)
- Negative drug test (prior to clinicals)
- PPD/Tuberculin skin test within past 12 months. PPD/Tuberculin skin testing is valid for one (1) year from date of administration. Students will be required to maintain current PPD/Tuberculin skin testing throughout the duration of the program. Students who test positive for tuberculosis must show proof of a negative chest x-ray taken within the past five years to satisfy this requirement.

Criminal Background Check/Livescan Fingerprinting

All applicants must undergo a Level 2 criminal background through the Florida Board of Nursing. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear background. The cost varies depending on the vendor the student chooses. If an applicant has any questions with this requirement, they must contact the Florida Board of Nursing directly at (850) 488-0595.

The Florida Board of Nursing is responsible for protecting the public. In carrying out this responsibility, the Board of Nursing reserves the right to deny licensure to anyone who has been convicted of a crime other than minor traffic violations. Pursuant to Section 456.0635, Florida Statutes, the Florida Board of Nursing shall refuse to issue a license, certification or registration and shall refuse to admit a candidate for examination if the applicant has been:

- **Convicted or plead guilty or nolo contender (No Contest) to a felony violation regardless of adjudication of chapters 409, 817 or 893, Florida Statutes; or 21 U.S.C. ss. 801- 970 or 42 U.S.S. ss 1395-1396, unless the sentence and any probation or pleas ended more than 15 years prior to the application.**

- **Terminated for cause from Florida Medicaid Program (unless the applicant has been in good standing for the most recent five years).**

- **Terminated for cause by any other State Medicaid Program or the Medicare Program (unless the termination was at least 20 years prior to the date of the application and the applicant has been in good standing with the program for the most recent five years).**

Acceptance into Program/Registration

South Florida Healthcare Institute accepts applicants into all Health Education programs on a rolling admission basis. As we receive applications, potential students are scheduled for an interview with the Program Director or their assignee. Once an applicant has completed the interview, they will be notified of their admission status. Accepted applicants will be given an acceptance letter, which will allow them to register for the program they have applied to. SFHI Health Education programs may be closed prior to the posted application deadline date once that program has reached capacity. Questions regarding the application process should be directed to Mrs. Leonora Creary at 800-816-3489.

Orientation

After being accepted into the SFHI PN Program, applicants will be notified about attending a mandatory orientation. The date(s) and time(s) of this meeting will be given to all accepted students within their acceptance letter. For further information, please contact Mrs. Leonora Creary - Program Director at 800-816-3489 or leonora@sflhealthcareinstitute.com

Uniforms and Nursing Kit

Upon acceptance students are expected to wear the specified program uniform whenever they are in the classroom, clinical simulation or clinical facility. You will receive information on how to order your uniforms and nursing kits during orientation. This is not included in your program tuition. Questions regarding proper attire and uniforms should be directed to the Program Director at 800-816-3489.

SUCCESSFUL COMPLETION OF THIS PROGRAM DOES NOT GUARANTEE LICENSURE AS A LICENSED PRACTICAL NURSE.

South Florida Healthcare Institute
7700 West Camino Real, Suite 401, Boca Raton, FL 33433
Practical Nursing Application Checklist

Include This Checklist with your Application

☐ Health Education Student Information Sheet

☐ Writing Sample

☐ One current reference letter

☐ HESI Official Results

☐ Student School Physical Form

☐ Immunization Records or Titers

☐ Receipt of Payment for a Level II Criminal Background Check

☐ Basic Life Support Certification
American Heart Association or American Red Cross ONLY

☐ Meet with Nursing Program Director
Provide official transcripts the day of appointment or you can submit official transcripts electronically at transcripts@sflhealthcareinstitute.com or mailed to South Florida Healthcare Institute, Attn: Nursing Program Director, 7700 West Camino Real, Suite 401, Boca Raton, FL 33433. You only meet with the Program Director virtually/in person, once you have a completed application.

Paying or Financing Tuition:

☐ Self-Pay student (20% deposit required, monthly payment plan) or

☐ Financing tuition through Meritize. (Check for qualification prior to submitting application).

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Health Education Student Information Sheet

Personal Information

Date _____

Date of Birth
_____

Last Name _____ First Name _____ MI _____

Address _____ City/State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Email Address _____

Emergency Contact _____ Phone# _____

Education

High School _____ City/State _____

Highest grade completed _____ Year _____ Choose one: ☐ High School Diploma ☐ GED

Previous Nursing School _____ City/State _____

College _____Degree awarded _____ City/State _____

Military
_____

Education as ☐ Certified Nursing Assistant ☐ Patient Care Assistant ☐ Patient Care Technician ☐ Medical Assistant

Name of School_____

Certification Awarded ☐ Yes ☐ No Date the Certificate Awarded _____
Proof required at time of application

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Health Education Student Information Sheet

Employment Record

Present _____ Title/Position _____

Dates of Employment: From _____ to _____

Present _____ Title/Position _____

Dates of Employment: From _____ to _____

Present _____ Title/Position _____

Dates of Employment: From _____ to _____

The information on this application is true and factual.

Signature: _____ Date: _____

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Writing Sample

Please answer the following question:

Why have you chosen to pursue nursing as a career?

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Applicant Reference Form

TO BE COMPLETED BY APPLICANT

Name of Applicant _____ Date of Birth ____/____/____

I have applied for admission to the Practical Nursing Program at South Florida Healthcare Institute (SFHI). I authorize you to provide SFHI with information regarding my suitability for admission. I further agree that the information will not be disclosed to me, and I hereby waive my right to review this reference.

_____/_____
Applicant's Signature Date

TO BE COMPLETED BY REFERENCE

1. How long have you known the applicant? _____

2. In what capacity have you known the applicant? ☐ Teacher ☐ Co-Worker ☐ Supervisor ☐ Other _____

3. How well does the applicant work with people? _____

4. Do you have any reservations regarding the applicant's potential for this career? ☐ No ☐ Yes

Please consider this applicant in relation to the Personal Qualities below. Indicate your rating by checking the appropriate box.

PERSONAL QUALITIES	ABOVE **AVERAGE**	AVERAGE	BELOW **AVERAGE**	NOT APPLICABLE	**COMMENTS**
Ability to handle stress					
Ability to work under pressure					
Accepts criticism					
Adaptability/accepts change					
Appearance & grooming					
Attitude					
Dependability/Reliability					
Emotional maturity					
Friendliness					
Initiative					
Interpersonal communication					
Judgment					
Loyalty					
Mental alertness					
Performance/Productivity					
Punctuality/Attendance					
Safety awareness					
Sincerity/Honesty					
Social skills					

NOTE: Please return this form to the SFHI Admissions Department as quickly as possible via fax: 800-816-3489, email: transcripts@sflhealthcareinstitute.com, or mail: South Florida Healthcare Institute – 7700 West Camino Real, Suite 401, Boca Raton, FL 33433. Applicant cannot be considered until this reference is returned. We ask for your further comments and observations. Attach a separate sheet of paper if necessary.

_____/_____ _____
Reference Signature Date Please print name

_____/_____ (_____) _____
Your Occupation/Position Company Name Phone Number for Verification

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Medical History and Student Exam Form

Last Name	First Name	Student ID #

Review of Systems / Medical History — please check all that apply			
Abnormal Bleeding		Hepatitis	
Allergies – Latex, Penicillin, Ampicillin, Other		Hernia	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Arthritis		Intestinal / Stomach Trouble	
Asthma		Low Back Condition / Scoliosis	
Cancer of		Mononucleosis	
Chest Pain		Neck Condition	
Chronic Cough		Neurological Disorder	
Concussion / Head Injury		Orthopedic Disorder	
Emotional Disturbance		Prior Surgery	
Depression		Rheumatic Fever	
Diabetes		Seizure Disorder	
Ear Trouble / Hard of Hearing		Sickle Cell Trait	
Eating Disorder		Sinus Problems	
Eye Trouble / Vision Loss		Skin Disease	
Fracture of _____		Splenectomy	
Gallbladder Disease		Sprain of _____	
Headaches / Migraines		Syncope / Fainting	
Heart Murmur or Arrhythmia		Thyroid Disease	
Heart Problems (other)		Tuberculosis	

Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months		
PPD Test Date	Attach supporting documentation	
Date & Time Administered	Administered by	
Manufacture of PPD	Expiration Date	Lot Number
Date Read	Read By	
Results in Millimeters of Induration		
If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required		
Chest X-ray Date	Attach Results of Chest X-ray	Examiner's Initials

Flu Vaccine - seasonally between September 15 & March 31		
Date of Vaccine	Injection Site	Attach supporting documentation
Lot Number	Expiration	Examiner's Initials

Please indicate any health concerns that you presently have and provide information regarding any of the boxes checked above.

_____

_____

_____

Information detailed on the Medical History and Physical Examination form is legally privileged and confidential. It is intended for use by the Health Science program unless written consent has been provided for release to other parties.

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Medical History and Student Exam Form

Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with people in various health care settings. Please indicate/comment on any abnormal findings; using additional sheets if necessary or providing further documentation.

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

SYSTEM	NORMAL	FINDING	COMMENTS/PREVIOUS CONDITIONS/SURGERY
Cardiovascular			
Endocrine/Metabolic			
Eyes/Ears/Nose /Throat			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurological			
Respiratory			

Is the student under treatment for any medical, surgical or emotional/psychological condition? **YES** **NO**
If yes, please provide details:

_____

Is the student now taking any medications? **YES** **NO**
If yes, please list:

_____

Is the student limited from participating in physical activities in the clinical area? **YES** **NO**
If yes, please specify limitations:

_____

Does the student require any follow-up health supervision? **YES** **NO**
If yes, please specify:

_____

Within the last 5 years, has the student been treated for any substance related (drug/alcohol) disorder? **YES** **NO**
If yes, please specify:

_____

EXAMINER'S NAME (PLEASE PRINT)_____ **PHONE** _____

ADDRESS_____ **CITY**_____ **STATE** _____ **ZIP**_____

SIGNATURE OF MD/DO/ARNP _____ **DATE** _____

LICENSE # _____

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Medical History and Student Exam Form

Based on today's history and medical examination, I found this patient to have no major health or physical limitations that would limit them from performing their current job duties.

Provider Name: _____ Provider Signature: _____

Provider Stamp: _____ Date: _____

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Student Immunization or Titers Record

THIS FORM MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER or attach your immunization record. Any falsification of this record will result in immediate dismissal from the program (if accepted).

NAME (please print):

_____
Last First MI

DATE OF BIRTH: ____ / ____ / ___

1. **MMR** (Need proof of two MMR vaccines or one mumps, two measles, and one rubella. Any person born before 1/1/57 will need proof of rubella immunization or positive titer.)

Date of MMR #1: _____ Date of MMR #2: _____
OR

Antibody titers:
Mumps titer date: _____ Results: □ Immunity □ Not immune

Rubeola titer date: _____ Results: □ Immunity □ Not immune

Rubella titer date: _____ Results: □ Immunity □ Not immune
If not immune, will require MMR x2.

2. **Hepatitis B series:**

_____
Hepatitis B #1 date Hepatitis B #2 date Hepatitis B #3 date
OR

Antibody titer date: _____ Results: □ Immunity □ Not immune
If not immune, or you did not receive the complete series, you may sign the Hepatitis B Declination Form.

3. **Varicella**: History of having Chicken Pox is not accepted.

Date of 1st dose: _____ Date of 2nd Dose _____
OR

Varicella titer date: _____ Results: □ Immunity □ Not immune

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Student Immunization or Titers Record

4. PPD (TB Skin Test): _____ Date taken: _____

Results: _____ Positive ____ Negative ____

Chest x-ray, if positive PPD: _____Date: _____ Results: _____
Attach Chest-ray documentation

5. Seasonal Flu Vaccine: Date of Vaccine: _____Injection Site: _____

(September - March) Lot Number Expiration: _____ Examiner's Initials: _____

Verified by:

_____
Name of Physician's Office/Health Center

_____
Physician's Signature

_____
Address of Office Date

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Hepatitis B Declination Form

DECLINATION: I understand that due to my occupational exposure to blood or other potentially infectious materials that I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can do so at any time.

I acknowledge that I have declined receiving the full hepatitis B vaccination series.
_____ (initial here)

Student Name: _____

Student Signature: _____

Date: _____

Electronic Fingerprinting Form

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the livescan method.
- You can find an approved Livescan Service Provider at: http://www.flhealthsource.gov/background-screening/ (*Click on Livescan Service Providers*)
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan Service Provider the Board office will not receive your background screening results.
- You must provide accurate demographic information to the Livescan Service Provider at the time your fingerprints are taken, ***including your Social Security number (SSN).***

- The Board of Nursing ORI number is -***EDOH4420Z***

- Typically background screening results submitted through a Livescan Service Provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ Social Security Number: _____

Aliases: _____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Race: _____ (W-White/Latino (a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ Weight: _____ Height: _____
(M=Male F=Female)

Eye Color: _____ Hair Color: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan Service provider.)

You will need to keep this form for your records. Do not send this form to the Board Office.