

**MOUNT CARMEL COLLEGE OF NURSING**  
**GRADUATE CERTIFICATE IN NURSING EDUCATION**  
**ADMISSIONS APPLICATION**

Thank you for your interest in applying for admission to the Graduate Certificate in Nursing Education Program at Mount Carmel College of Nursing. This program has two options—an on-line program or a traditional on-site program.

The admission requirements for the program include:

- ✓ Master's Degree in nursing (MS or MSN) from an accredited program; accreditation by either the National League for Nursing Accrediting Commission or the Commission on Collegiate Nursing Education
- ✓ Current unrestricted Registered Nurse license

Admission applications are accepted for Fall Semester, Winter Semester, and Summer Session. Students may enter the program and begin studies for any one of the three semesters. The admission materials to be submitted for consideration in the program include:

- ✓ Completed application form and \$30 application fee
- ✓ Official transcript (s) from master's program in Nursing
- ✓ Current resume

Traditional On-Site Classes for the program are scheduled on Wednesdays.

When completing the precepted practicum, students must meet the compliance requirements of all agencies.

Mount Carmel College of Nursing is an equal opportunity educational institution.

Send all inquires and admission materials to:

**Ms. Kip Sexton, M.S., R.N.**  
**Graduate Program Advisor**  
**Mount Carmel College of Nursing**  
**127 South Davis Avenue**  
**Columbus, OH 43222**  
**esexton@mchs.com**  
**(614) 234-5169**

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ADMISSION APPLICATION

**Personal Information:** PLEASE PRINT

- Fall  
 Winter  
 Summer \_\_\_\_\_
- On-line  
 On-site

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Semester / Year you plan to enroll

\_\_\_\_\_  
LAST NAME FIRST NAME MI PREVIOUS NAMES (if any)

\_\_\_\_\_  
MAILING ADDRESS

\_\_\_\_\_  
CITY STATE ZIP COUNTY OF RESIDENCE

\_\_\_\_\_  
WORK TELEPHONE NUMBER HOME PHONE NUMBER

\_\_\_\_\_  
CELL PHONE NUMBER E-MAIL ADDRESS

\_\_\_\_\_  
EMPLOYER'S NAME AND ADDRESS

\_\_\_\_\_  
IN CASE OF EMERGENCY, PLEASE CONTACT

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
PHONE NUMBER(S)

CITIZENSHIP: \_\_\_\_ U.S. citizen \_\_\_\_ Permanent Resident \_\_\_\_ Nonresident alien

THE FOLLOWING INFORMATION IS USED FOR REPORTING PURPOSES:

GENDER: Male \_\_\_\_ Female \_\_\_\_ MARITAL STATUS: Married \_\_\_\_ Unmarried \_\_\_\_

BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ETHNICITY:  African American  Asian  American Indian  Caucasian  Hispanic  Other

**Academic Information:**

RN LICENSURE: STATE(S) \_\_\_\_\_

NUMBER \_\_\_\_\_

\_\_\_\_\_  
COLLEGE WHERE RECEIVED MASTER'S (MS OR MSN) IN NURSING YEAR OF GRADUATION

\_\_\_\_\_  
LIST ALL OTHER COLLEGES ATTENDED, DATES ATTENDED, AND ANY DEGREES EARNED

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