

FAIRFIELD UNIVERSITY
SCHOOL OF NURSING
FAIRFIELD, CT 06824-5195

**APPLICATION FOR MATRICULATION
RN-BSN PROGRAM**

Instructions for completion:

- A. Return the completed form together with a non-refundable application fee of \$60.00. Make check or money order payable to Fairfield University.
- B. Have an official copy of any college transcript(s) sent directly to the School of Nursing, RN-BSN Program.
- C. Provide a copy of your resume.
- D. Proof of Immunization is required for students born after 1/1/57. If applicable, complete and return an Immunization Information form.
- E. Submit two letters of recommendation, one of which must be from a current supervisor or professor.
- F. Schedule an interview with the Adult Program Director

Name _____
Last First Middle Maiden

Address _____
Street City State Zip Code

SS# (optional) _____ Email Address: _____

Home Telephone: (____) _____ Business Telephone: (____) _____

Gender: Female _____ Male _____ Date of Birth: _____

U.S. Citizen: Yes _____ No _____

If *No*, do you hold a Permanent Resident Card? ___Yes ___No If Yes, provide card # _____

Veteran? Yes _____ No _____

Marital Status _____

Ethnic Background ___African-American ___American Indian or Alaskan Native ___Asian or Pacific Islander
(*optional*)
___Hispanic or Latino ___White (Non-Hispanic) ___Other (*please specify*) _____

Term in which you would like to begin study:

Fall _____ Spring _____ Summer _____ 200_____

In case of emergency, contact:

Name _____

Address: _____
Street City State Zip Code

Telephone: (____) _____ Relationship: _____

Do you have any disabilities which will require special help or services? _____

Work Experience (list present or most recent position first):

Employer's Name and Address	Position Held	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Education (please list in chronological order)

High School	City & State	Years Attended	Diploma
_____	_____	_____	_____
College/University	City & State	Years Attended	Degree Earned
_____	_____	_____	_____
_____	_____	_____	_____

Licensure:

Type of License	State	Expiration Date
_____	_____	_____
_____	_____	_____

Letters of recommendation may be requested at the discretion of the School. Please list two persons, other than relatives, who can provide character references for you.

Name	Address
_____	_____
_____	_____

Financial Aid:

Students accepted into the program must be provisionally matriculated. Provisional matriculation also makes you eligible to apply for Financial Aid. ***Please check here if you believe you will be applying for Financial Aid*** _____

I certify that the above information is correct and complete to the best of my knowledge. I have read the catalogues of Fairfield University and agree to the terms therein.

Applicant's Signature _____
Date

*****OFFICE USE ONLY*****

Matriculated _____ Curriculum _____ Transfer Credits _____

Approval _____ Date _____

PLEASE TYPE OR PRINT CLEARLY:

Name (Last, First, Middle)

Date of Birth

Sex

Home Address (Street, City, State, Zip)

SS # (optional)

IMMUNIZATION HISTORY

Applies to Students Born After January 1, 1957
(To be completed by Physician)

Proof of the following immunization is necessary as defined by the State of Connecticut:

Measles: Two doses of measles vaccine administered at least one month apart. The first dose must have been given after one year of age and after 1/1/69; the second dose must have been given after 1/1/80.

Rubella: (German Measles) One dose of vaccine administered after the first birthday.

PROOF OF THE ABOVE IMMUNIZATIONS OR LABORATORY PROOF OF IMMUNITY MUST BE SUBMITTED.

Measles	Rubella
1 st Dose mm/dd/yy	1 st Dose mm/dd/yy
2 nd Dose mm/dd/yy	

I certify that this student has received the immunizations indicated.

Physician Signature

Date