Capital Area Career Center
Capital Area School of Practical Nursing (CASPN)
2201 Toronto Road ▪ Springfield, IL ▪ 62712-3803
Phone (217) 585-1215 ▪ FAX (217) 585-2165
http://caspn.edu/

Please read this page before beginning the application process.

Applicants are accepted into the Practical Nursing Program on a first-come, first-served basis. Each class is limited to sixty-five (65) students, who are accepted in order of completion of the admission requirements. Applicants completing the process after the class is filled will be placed on a waiting list. If an opening does not become available, the applicant will be accepted for the next scheduled class start date. All requirements must be met by the designated application deadline. Applications are kept on file for one year after submission. After one year, all documents expire, including the application fee**. No refunds are given for the Application or TEAS entrance exam fees.** The application process consists of the following parts:

Personal Information/Personal Health Form/ Academic Transcripts/ CNA Certification

The **Personal Information and Release of Criminal Background** forms must be completed and returned with a $75.00 application fee before applications may be processed. Applicants may take the pre-entrance (TEAS) examination after these items are submitted. However, the application process is not complete until **all** documents on the Admissions Checklist are received.

Applicants must submit a copy of their official high school or GED transcript. College transcripts will **not** be accepted as proof of graduation from high school.

Applicants must have completed a state-approved CNA program **AND** passed the Illinois CNA Competency Exam prior to acceptance into the LPN program. This qualification will be verified with the Illinois Department of Public Healthcare Worker Registry.

PRE-ENTRANCE EXAMINATION (ATI TEAS)

All students entering the Practical Nursing Program must take the Pre-Entrance ATI TEAS Examination regardless of college hours or ACT Score. The $65.00 examination fee must be paid **one week** in advance. **NO MONEY WILL BE ACCEPTED THE DAY OF THE EXAM**. The test may be attempted three (3) times per year; however, the $65.00 testing fee must be paid each time. The test consists of four parts—Math, Reading, English, and Science. You should achieve an individual score of 54% in each portion of the exam excluding Science. Therefore, a score of 54% in Mathematics, 54% in Reading Comprehension, and 54% in English, along with a score of 40.4% in Science should be achieved to be considered a passing score. Study books are available from the ATI website. Tests must be scheduled at least one week in advance by the Adult Education Secretary.

PHYSICAL EXAMINATION

A Healthcare Professional must complete the physical examination form. All required lab tests must be current within twelve (12) months of admission into the program. The drug screen must be completed upon enrollment.

Applicants must include a lab report of their drug screen with the CASPN physical form. All immunization information MUST include dates of immunization, dates of titers, or documented history of the disease. At least the first two steps of the Hepatitis B vaccine must be completed for admission with step 3 completed as scheduled.

BACKGROUND CHECKS/DRUG SCREENS/CPR CERTIFICATION

CASPN requires criminal background checks of all students who wish to be enrolled prior to entrance into the nursing program through a company selected by CASPN. The student application packet is not considered complete until the background check is clear or waiver received.

A 10-panel urine drug screen will also be required at the applicant expense. This can be done by a physician's office, clinic visit, Quest Diagnostics, or Midwest Occupational Health Associates (MOHA) in Springfield.

Basic Life Support (BLS) Provider for CPR certification must be through the American Heart Association and is required before entering the program. CPR certification must remain current throughout the program.

Please notify the Admissions Specialist if there is any change in your personal information (name, address, phone number or e-mail address) during the application process.

FINANCIAL AID

All students that intend to apply for Financial Aid must complete a FAFSA as soon as possible. A FAFSA can be done at any time during the year but your eligibility for certain grants depends on your Expected Family Contribution (EFC) and when your FAFSA is completed.

The website to apply for financial aid is www.FAFSA.ed.gov Our School Code is **016426**.

CAPITAL AREA SCHOOL OF PRACTICAL NURSING ADMISSIONS CHECKLIST

Once all of these steps have been completed, and the background check has been passed, applicants will be placed on the roster for the next available class. Applicants will receive a letter informing them of their acceptance into the program. This checklist is provided for you to track your progress in the application process:

APPLICATION FORMS SUBMITTED

Personal Information Date: _____
Authorization for Release of Criminal Background Information Date: _____
$75 Application fee Date: _____

PRE-ENTRANCE (ATI TEAS) EXAM SCHEDULED

$65 fee due one week prior to date of test Date: _____
Photo ID required for entrance to test

HIGH SCHOOL TRANSCRIPT OR GED TRANSCRIPT

Official High School or GED Transcript submitted Date: _____

PHYSICAL EXAM FORM/PROOF OF IMMUNIZATIONS SUBMITTED

Physical Exam performed within last 12 months Date: _____

Immunizations

TB test: 2 Step PPD, Chest X-Ray or Quantiferon
(Within last 90 Days) Date: _____

MMR Vaccine or Date: _____
Rubella Titer or Vaccine Date: _____
Rubeola Titer or Vaccine Date: _____
Mumps Titer or Vaccine Date: _____
Tdap Vaccine (within last 10 years) Date: _____
Hepatitis B Titer or Vaccine Date: _____
(at least Steps 1 & 2 completed)
Varicella Titer or Vaccine or Date: _____
(Healthcare Provider documentation of the disease)

10-Panel Drug Screen Date: _____

CPR

Current BLS Provider CPR Card from AHA submitted Date: _____
CPR card must be from American Heart Association

CNA CERTIFICATION

CNA Certification (MUST be on the Illinois Department of Public Health: Health Care Worker Registry) Date: _____

Updated: 12/20/2019

Personal Information Form

Please complete and return this form with the non-refundable fee of $75.00 **money order** to the Capital Area School of Practical Nursing as soon as possible.

Please submit this form along with the Release of Criminal Background form before you send transcripts, or physical exam forms.

CLASS DESIRED: February_____Year_____ or August_____Year_____

NAME:_____
Last First Middle Maiden

ADDRESS:_____
Street City State Zip Code County

TELEPHONE:_____**CELL PHONE:**_____**EMAIL:**_____

ARE YOU A U.S. CITIZEN? Please check the appropriate box.

- ☐ Yes, I am a U.S. Citizen.
- ☐ No, but I am an eligible non-citizen. **ALIEN** | | | | | | | | | | **REGISTRATION #**
- ☐ No, I am not a citizen or eligible non-citizen.

SOCIAL SECURITY NUMBER: _____

EMERGENCY CONTACT: Name_____Phone_____Relationship_____

Address_____
Street City State Zip Code

EDUCATION: Give name, city and state of each school. (Use the back of the page if needed.)

High School_____Date Graduated or GED obtained_____

College_____Dates Attended_____

OPTIONAL INFORMATION: It is NOT mandatory to fill out this section. The following questions are voluntary and are not used in the selection process.

Marital Status: Single__Married ___Separated__Divorced____Widow___

Number of children: _____Ages_____

How did you hear about CASPN?_____

Do you know someone in the program currently or a past graduate? (Specify) _____

What is the distance from your home that you will travel to attend CASPN? _____ miles

Updated: 12/20/2019

PLEASE COMPLETE THE FOLLOWING INFORMATION.

EMPLOYMENT INFORMATION:

Present Employer_____

Position_____ Dates of Employment_____

Previous Employment**:** List most recent employment first.

Name of Employer	Address (Street, City, State)	Dates of Employment
Name of Employer	Address (Street, City, State)	Dates of Employment
Name of Employer	Address (Street, City, State)	Dates of Employment

CRIMINAL HISTORY:

Have you ever been convicted of any criminal offense in any state or in federal court (other than for minor traffic violations)? Yes ____ No ____

If yes, please contact the Admissions Specialist of the Nursing Program before submitting this form.

Please write a short statement of why you want to be a Practical Nurse.

I understand that false statements or omissions of any part of the application may be considered sufficient cause for denial of admission or dismissal from the program.

Date_____ Signature_____

Please Send Application To:

Capital Area School of Practical Nursing

2201 Toronto Rd

Springfield, IL 62712

The Capital Area School of Practical Nursing offers practical nursing education opportunities without regard to age, color, race, sex, nationality, religion or religious affiliation, physical limitations/disability, sexual orientation, ancestry, marital status, pregnancy or veteran status.

Updated: 12/20/2019

CAPITAL AREA SCHOOL OF PRACTICAL NURSING

AUTHORIZATION FOR RELEASE OF CRIMINAL BACKGROUND INFORMATION

(School Purposes)
TO BE COMPLETED BY STUDENT
(PLEASE PRINT LEGIBLY)

LAST NAME:_____ **FIRST NAME:**_____ **MIDDLE NAME:** _____

MAIDEN NAME OR OTHER ALIASES:_____

SOCIAL SECURITY NUMBER: _____/_____/_____ **SEX:** MALE _____ FEMALE_____

DATE OF BIRTH: _____/____/_____ **PLACE OF BIRTH**: _____

Month Day Year

RACE: WHITE BLACK ASIAN AMERICAN INDIAN/ALASKA NATIVE HISPANIC/LATINO PACIFIC ISLANDER UNKNOWN

DRIVERS LICENSE #_____ **STATE ISSUED**_____

CURRENT ADDRESS:_____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

PAST COUNTIES AND STATES WHERE YOU HAVE LIVED:
_____

_____

_____

_____

Student Authorization

Without reservation, I authorize Capital Area School of Practical Nursing (CASPN) to procure my background check to obtain or furnish information concerning my criminal or other history. I understand that inquiries may be made to various federal and state agencies, employers, references, acquaintances, and others seeking information as to my personal characteristics, employment status, and general reputation.

Signature_____Date_____

This information is requested by CASPN for purposes of insuring accurate retrieval of records for acceptance into the nursing program.

CASPN Fax Number 217-585-2165

TO BE COMPLETED BY CASPN STAFF ONLY

Date background received_____ CASPN Staff Initials_____

Updated: 12/20/2019

Capital Area School of Practical Nursing

Student Physical Examination Form

2201 Toronto Road
Springfield, Illinois 62712-3803
Phone: 217-585-1215
http://caspn.edu/

Date_____

Name	
DOB	
Street Address	
City, State, Zip	
Cell Phone	
Email Address	

HEALTH QUESTIONNAIRE TO BE COMPLETED BY APPLICANT:

	Check Appropriate Box Yes	No
Do you have any physical limitations that would affect your ability to lift, turn or transfer patients or equipment?		
Do you have any limitations in use of your senses, such as in sight or hearing, which would limit your ability to practice as a health professional?		
Do you have any other condition that might interfere with your ability to practice in the health profession?		

If you answered **"Yes"** to any of the above, please explain:

Include any significant information regarding previous medical, surgical, psychiatric conditions and any use of alcohol and/or drugs:

Are you currently pregnant? _____ If yes, when is your due date? _____

Updated: 12/20/2019

TO BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER

General Appearance:				
Height	Weight	B/P	Pulse	Respirations

Check the appropriate boxes below:

Physical Findings	Normal	Abnormal	Describe Abnormality (Use separate sheet if needed)
Eyes, Ears, Nose & Throat			
Endocrine			
Cardiovascular			
Respiratory			
Gastrointestinal			
Musculoskeletal			
Extremities			
Skin			
Neurological			
Mental Health			

Medication taken on regular basis or as needed:

Date Started	Medication	Dosage	Route	Indications

Allergies:_____

Updated: 12/20/2019

Essential Functional Abilities of the Nursing Student

Each student must have a complete physical examination and have their healthcare provider initial each section and sign at the bottom of this form prior to entering the program.

Issue	Examples of Necessary Activities Not all-Inclusive	Standard
Mobility Reviewed by _____ *initials*	Move from place to place independently, maneuver to perform nursing activities, move in small spaces, perform CPR, lift 50 pounds and exert up to 100 pounds force to push/pull. Able to bend, squat, kneel, twist, reach above shoulder level and climb stairs. Able to stand for extended periods of time	Physical abilities to sufficiently care for patients in small spaces and move from room to room.
Motor Skills Reviewed by _____ *initials*	Perform manual psychomotor skills by maintaining balance in standing and sitting positions, hand and finger coordination allowing the student to grasp, twist, pinch and squeeze. Able to position patients, use hands repetitively, travel to/from academic sites. Able to complete electronic documentation	Gross and fine motor skills sufficient to provide safe and effective care.
Hearing Reviewed by _____ *initials*	Hear monitor alarms, pump alarms, call bells, intercom, emergency alarms, auscultatory sounds, and patient's or visitor's call for help.	Auditory ability sufficient for monitoring and assessing health needs.
Visual Reviewed by _____ *initials*	Observe patient for multiple needs: Skin assessment, wound assessment, color changes, medication administration. Able to read the information on a computer screen. Depth perception.	Visual ability sufficient for observation, assessment and documentation for safe nursing care.
Communication Reviewed by _____ *initials*	Interact with others, speak, write and understand English at a level to effectively communicate with patients as well as report and document patient information. Understand flow charts, graphs to interpret data and enter date. Read and understand digital and computer displays. Initiate health teaching.	Abilities sufficient for verbal, nonverbal and written communication with patients, families and other healthcare providers.
Emotional Stability Reviewed by _____ *initials*	Interact and support patients during times of stress and emotional upset, adapt to changing and emergency situations while maintaining emotional control, manage patients with strong emotions and physical outburst while remaining in a reasonably calm state, deal with numerous interruptions and multiple demands while still completing tasks	Stable emotional state to care for patients with strong emotional situations, ensuring patient safety.

I certify that the above named student has been examined by me. This student is found to be in good physical and mental health as outlined above. I have determined that this student may participate in laboratory, lecture and clinical experiences with NO restrictions.

_____ _____

Healthcare Provider Signature Date

Printed Name and Title: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

Updated: 12/20/2019

ALL OF THE BELOW ITEMS ARE REQUIRED BEFORE ADMISSION

10-Panel Drug Screen:

Date:	Drug Name:	Negative:	Positive	Date:	Drug Name	Negative	Positive
	Amphetamines				**Methadone**		
	Barbiturates				**Methaqualone**		
	Benzodiazepines				**Opiates**		
	Cocaine				**Phencyclidine (PCP)**		
	Marijuana				**Propoxyphene**		

Immunization Records:

Mumps: Select option 1 or 2 and provide documentation.

Option 1: Immunization Dates Date of first immunization:_____ Date of second immunization:_____

Option 2: Blood Titer Date of blood titer:_____ Quantitative result of blood titer:_____

RUBEOLA (MEASLES): Select option 1 or 2 and provide documentation.

Option 1: Blood Titer Date of blood titer:_____ Quantitative result of blood titer:_____

Option 2: Immunization Dates Date of first immunization:_____ Date of second immunization:_____

RUBELLA (GERMAN MEASLES): Select option 1 or 2 and provide documentation.

Option 1: Immunization Dates Date of first immunization:_____ Date of second immunization:_____

Option 2: Blood Titer Date of blood titer:_____ Quantitative result of blood titer:_____

HEPATITIS B: Select option 1 or 2 and provide documentation. Date of first immunization:_____

Option 1: Immunization Dates Date of second immunization:_____ Date of third immunization:_____

Option 2: Blood Titer Date of blood titer:_____ Quantitative result of blood titer:_____

TUBERCULOSIS: Select option 1, 2 or 3 and provide documentation.

Option 1: 2 step TB test Step 1 - PPD Date:_____ Step 1 - PPD Results:_____

Step 2 - PPD Date:_____ Step 2 - PPD Results:_____

Option 2: Chest x-ray within the last 12 months Date of chest x-ray:_____ Results of chest x-ray:_____

VARICELLA (CHICKEN POX): Select option 1 or 2 and provide documentation.

Option 1: Immunization Dates Date of first immunization:_____ Date of second immunization:_____

Option 2: Blood Titer Date of blood titer:_____ Quantitative result of blood titer:_____

Tdap (Tetanus, diphtheria and pertussis) Date of immunization:_____

Updated: 12/20/2019