LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Nursing

Graduate Program

Application for Admission

LSUHealthNewOrleans
HEALTH SCIENCES CENTER
School of Nursing

Application General Information

Thank you for your interest in the Graduate Program at Louisiana State University Health Sciences Center School of Nursing. We welcome and appreciate your application. This application contains all of the required application forms. Please submit a complete application including your transcripts, Graduate Record Examination (GRE) scores, if required, and recommendations on the form provided. The review of your application may not be completed until the Office of Student Affairs has received all items listed below. Please refer to the check list on page 5.

Please read this general information about application requirements carefully prior to completing the application. Check each box to indicate you have read and/or completed the required information. The Application General Information section should be completed and submitted to the LSUHSC School of Nursing Office of Student Affairs along with the completed Application form.

APPLICATION DEADLINE

- ☐ BSN-DNP
  The BSN-DNP program admits once a year. The deadline for submission of applications for the summer admission to the BSN-DNP program is September 1st.
- ☐ Post-Masters DNP
  The deadline for submission of applications for the fall admission is February 1st, spring admission September 1st, summer admission January 15th
- ☐ MSN Nurse Educator
  The deadline for submission of applications for fall admission is February 1st, spring admission September 1st, summer admission January 15th

Any exception to this admission schedule is directed to the Director of the program.

TRANSCIPTS AND GRE SCORES

- ☐ Official transcript(s) from a regionally accredited college or university documenting the award of a BSN or a BSN Equivalent* and a Master's degree in nursing.** All previous undergraduate and graduate transcripts must be submitted. All nursing course credit earned must be from a specialized nursing accredited academic program.

  *A BSN Equivalent does not meet admission requirement without the conferral of a Master's degree.

  ** Students who have a Master's degree in another field may be accommodated on an individual basis as prescribed by the respective Program Director.

- ☐ A grade point average of 3.0 on a 4.0 scale for all undergraduate and graduate course work reflected on transcript (s). Transcripts, GRE scores, if required, are sent directly to the Office of Student Affairs.

- ☐ Official scores for the Graduate Record Exam (GRE) from within the past five years. **The GRE is not required for applicants applying to the post-Master's DNP Program**.

- ☐ A minimum score of 550 on the Test of English as a Foreign Language (TOEFL) for all applicants who have English as a second language or are not graduates of programs in the United States.

- ☐ *The Verification of Graduate Practicum Hours Form* must be completed and submitted with the application form for all post-Master's Doctor of Nursing Practice (DNP) applicants.

CLINICAL PRACTICE

- ☐ A minimum of one year of clinical nursing experience, some concentrations may require more years of experience:
  - Neonatal Nurse Practitioner concentration requires two years of experience in Level III NICU.
  - Nurse Anesthesia Program concentration requires a minimum of one year of full time critical care experience within the previous two (2) years at the time of application to the program.
  - Primary Care Family Nurse Practitioner concentration requires a minimum of one year direct patient care experience within the last 5 years.

RECOMMENDATIONS

- ☐ Submit three recommendations on the form provided in the application. One recommendation must be from a peer and the other one from a supervisor.

LICENSURE

- ☐ A current unencumbered RN license to practice nursing in any state with eligibility for licensure in Louisiana is required and must be presented at the time of enrollment. All

advanced practice registered nurses (APRN) applicants must also possess a current unencumbered APRN license to practice advanced practice nursing in any state with eligibility for licensure in Louisiana. The Louisiana license must be presented at the time of enrollment.

- ☐ Have you had a license to practice nursing or as another health care provider denied, revoked, suspended, sanctioned, or otherwise restricted or limited, including voluntary surrender of license - including restrictions associated with participation in confidential alternatives to disciplinary programs? Please check the box below:
  ☐ Yes ☐ No

and/or

- ☐ Have you had or currently have disciplinary or any investigative action pending by any licensing board, employer, or legal entity? Please check a box below:
  ☐ Yes ☐ No

SCHOLARLY WRITING

- ☐ One example of a published or unpublished scholarly paper written by the applicant and submitted with the application form. (post-Master's DNP and DNS Programs Only)

Please contact the School of Nursing Student Affairs with any questions at 504-568- 4113 or email nsstuaffairs@lsuhsc.edu.

LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Nursing

APPLICATION CHECKLIST

Please complete this form on-line, print and submit it to the School of Nursing Office of Student Affairs with your completed application packet. All of the following items must be submitted to be considered for admission to the LSUHSC School of Nursing Graduate Program.

- ☐ Completed Application Form
- ☐ Non-refundable Application Fee of $100 (check or money order)
- ☐ Publication or Scholarly Paper (**post-Masters DNP and DNS Programs Only**)
- ☐ Copy of APRN Certification (**post-Master's DNP only**)
- ☐ Verification of graduate practicum hours (**post-Master's DNP only**)
- ☐ Three (3) letters of recommendations
- ☐ Official Transcripts from all prior undergraduate and graduate coursework (Sent directly to the Office of Student Affairs)
- ☐ Current resume (**post-Master's DNP only**)
- ☐ Evidence of unrestricted licensure
- ☐ Applicants must request an official copy of GRE, if required, and/or TOEFL (international students only) scores be sent directly to the Office of Student Affairs. The School of Nursing can only accept official scores.
- ☐ Graduate Record Exam (GRE) results **(not required for post-Master's DNP**)
- ☐ Test of English as a Foreign Language **(TOEFL, if applicable)**
- ☐ Completed Nurse Anesthesia Practice Survey **(nurse anesthesia applicants only**)

_____

Signature of Applicant

_____

Date

LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Nursing

APPLICATION FOR ADMISSION

Directions: Answer all questions on-line by selecting the box or circle of the appropriate choice or by providing the requested information. Print the completed application and submit the application form and requested documents to the Office of Student Affairs.

Legal Name:

_____

Last First Middle Initial Maiden

I hereby apply for admission to the Louisiana State University Health Sciences Center School of Nursing Program for the:

☐Fall ☐Spring ☐Summer Year _____ ☐Part-time ☐Full-time

My intended program of study is the:

☐ **Master of Science in Nursing**
- ○ Nurse Educator

☐ **Doctor of Nursing Practice (DNP) BSN-DNP**
- ○ Nurse Anesthesia
- ○ Nurse Practitioner - Primary Care Family Nurse
- ○ Nurse Practitioner - Neonatal
- ○ Adult Gerontology Clinical Nurse Specialist
- ○ Public / Community Health Nursing
- ○ Executive Nurse Leader

☐ **Doctor of Nursing Practice (DNP) post-Masters**
- ○ Nurse Anesthesia
- ○ Nurse Practitioner
- ○ Clinical Nurse Specialist
- ○ Nursing Administration
- ○ Public / Community Health Nursing
- ○ Other, Specify your master degree area: _____

☐ **Doctor of Nursing Science (DNS)**

☐ **Non-Degree Seeking Student**
- ○ I intend to enroll in the concentration selected
- ○ I do not intend to apply or enroll in any area of concentration

Personal Data

1. **Legal Name:**

_____

Last First Middle Initial Maiden

2. **Permanent Home Address**:

_____
Number and Street Apt. Number

_____
City, State, and Zip Code Parish/County

3. **Mailing Address** (If different than Permanent Address)

_____
Number and Street Apt. Number

_____
City, State, and Zip Code Parish/County

4. **Telephone Number**:

Home: ( ) _____ Work: ( ) _____

Cell Phone: ( ) _____

5. **Email Address**: _____

6. **Date and Place of Birth**: _____ /: _____ /_____ _____
Month Day Year City/State/Country

7. **United States Citizen** ☐Yes ☐ No If No, state:_____

Country of Birth _____ Country of citizenship _____
Type of Visa _____ Status of Visa _____

8. **Social Security Number**: _____ - _____ - _____

9. **Gender:** ☐Female ☐Male

10. **Marital Status:**

☐Single ☐Married ☐Divorced ☐Legally Separated ☐Widowed

11. **Name and relationship of person to be notified in case of emergency:**

Name: _____
Name Relationship

Address: _____
Number and Street Apt. Number

_____
City/State and Zip

Telephone: Home: ( ) _____ Work: ( ) _____

Cell Phone: ( ) _____

12. **Data on Race and Ethnicity**

Please indicate which group(s) best describes you (you may select more than one):

Is your ethnicity Hispanic or Latino? ❑ Yes ❑ No

For individuals who are non-Hispanic/Latino what do you consider your race?

- ❑ Black or African American
- ❑ American Indian or Alaskan Native
- ❑Asian – Please also indicate
  - ○ Chinese
  - ○ Filipino
  - ○ Japanese
  - ○ Korean
  - ○ Indian
  - ○ Thai
  - ○ Vietnamese
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Caucasian
- ❑Two or more races
- ❑Race and ethnicity unknown
- ❑ Other _____

Economic Disadvantaged Status (*required* HRSA data):

Are you **economically disadvantaged** according to federal guidelines?	☐ Yes	☐ No

The HHS Secretary defines a "low-income family" for programs included in Titles III, VII and VIII of the Public Health Service Act as having an annual income that does not exceed 200 percent of the Department's poverty guidelines. A family is a group of two or more individuals related by birth, marriage, or adoption who live together or an individual who is not living with relatives. Most HRSA programs use the income of the student's parents to compute low income status, while a few programs, depending upon the legislative intent of the program, programmatic purpose of the low income level, as well as the age and circumstances of the average participant, will use the student's family as long as he or she is not listed as a dependent upon the parent's tax form. Each program will announce the rationale and choice of methodology for determining low income levels in their program guidance. The Department's poverty guidelines are based on poverty thresholds published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index.

2013 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,490
2	15,510
3	19,530
4	23,550
5	27,570
6	31,590
7	35,610
8	39,630

For families/households with more than 8 persons, add $4,020 for each additional person.

The Secretary annually adjusts the low-income levels based on the Department's poverty guidelines and makes them available to persons responsible for administering the applicable programs. The poverty guidelines for the remainder of 2012 are provided below. The guideline figures shown represent annual income. These guidelines will remain in effect until HHS publishes the 2013 poverty guidelines, which is expected in late January 2013.

Educational Disadvantaged Status (*required* HRSA data):

Are you **educationally disadvantaged** according to federal guidelines?	❑ Yes	❑ No

"Educationally Disadvantaged" means an individual who comes from an environment that has hindered the individual in obtaining the knowledge, skills and abilities required to enroll in and graduate from a health professions school. The following are provided as examples of "Educationally Disadvantaged" for guidance only and are not intended to be all-inclusive. Applicants should seek guidance from their educational institution as to how "Educationally Disadvantaged" is defined by their institution.

Examples:

1. Person from a high school with low average SAT scores or below the average state test results.
2. Person from a school district where 50% or less of graduates go to college.
3. Person who has a diagnosed physical or mental impairment that substantially limits participation in educational experiences.
4. Person for who English is not their primary language and for whom language is still a barrier to their academic performance.
5. Person who is first generation to attend college and who is from a rural or urban area or receiving public assistance.
6. Person from a high school where at least 30% of enrolled students are eligible for free or reduced price lunches.

13. The LSUHSC must show compliance with the Americans with Disabilities Act of 1990: If you require some type of special accommodation, you must schedule an interview

with the Assistant Dean for Student Services. If you desire an accommodation for your interview, please contact the Office of Student Affairs.

14. Are you now, or have you ever been a member of the Armed Forces? ☐ Yes ☐ No

If yes, date of discharge: _____

15. Male students, ages 18-26, should complete this section:
Louisiana state law requires you to register for the federal draft, under the Federal Military Selective Service Act, prior to your enrollment in any institution of the LSU System. Please sign your name on the line below, indicating you are in compliance with this state law:

I, _____, have registered with the Selective Service System in
(Type your name)

accordance with the Military Selective Service Act.

_____ _____
(Signature) (Date)

If you are not required to register with the Selective Service System, please indicate below the reason why:

_____

_____

_____

_____

Residence Data

1. Provide the following information concerning parents/ guardians

Father's Name_____
Last First Middle

Address: _____
Number/Street City/State Zip Code

Attended College ☐ Yes ☐No

Mother's Name_____

Last First Middle

Address: _____
Number/Street City/State Zip Code

Attended College ☐Yes ☐No

Are you or your parents LSUHSC Alumni? _____☐Yes ☐No

If yes, name, contact information and which school_____

2. Do you consider yourself to be a resident of Louisiana? ☐Yes ☐No

If yes, since Month _____ Year _____

3. Did you attend high school in Louisiana? ☐Yes ☐No

If No, in what state or country did you attend high school?

_____

4. Date you moved to your present home address: Month _____ Year _____

5. If you have been living at your present address less than two years, list previous home addresses for past two years:

_____
_
Number/Street City/State Zip Code Date

_____
Number/Street City/State Zip Code Date

COMPLETE Items 6 and 7 ONLY IF YOU ARE NOT PRESENTLY RESIDING IN LOUISIANA.

6. Have you ever resided in Louisiana? ☐ Yes ☐ No

If yes, From: Month _____ Year _____ To: Month _____Year_____

7. Are you participating in the Academic Common Market? ☐ Yes ☐ No

Educational / Professional Data

Education:
List all undergraduate and graduate degrees and institutions attended, beginning with last school attended. Use an additional page if necessary.

College/University	City/State	Dates Attended	Major	Degree Awarded

Honors: List any significant honors, awards, and honor society memberships

Honor	Institution	Year Awarded

Activities: List any major extracurricular, community, vocations or unique activities that you are involved with (Optional)

Activity	Years Participated	Office Held or Honor Received

Publications or Scholarly Writing: List any publications you have written			
Co-Author(s)	**Title**	**Journal**	**Volume & Number**

Employment: List the clinical settings in which you have practiced for the past 15 years. Recent employers may be contacted for references. Use additional page if needed.				
Agency (Current First)	**Address**	**Position & Responsibilities**	**Dates of Employment**	**Supervisor**

Certifications: Provide areas of professional certifications		
Title of Certification	**Certifying Body**	**Dates of Certification**

1. **If you have previously attended LSUHSC, list the names(s) under which you registered:**

_____ _____
Name Semester/Year

_____ _____
Name Semester/Year

2. **Have you ever been suspended or dismissed from any college or university for academic or disciplinary reasons?** ☐ Yes ☐ No

3. **In which states are you currently licensed to practice as a registered nurse?**

_____ _____ _____ _____
State State State State

4. **In which states are you currently licensed to practice as an Advanced Practice Registered Nurse?**

_____ _____ _____ _____

State State State State

5. **Has any disciplinary action, consent order or settlement been imposed or pending on your licensure in any of the above states?** ☐ Yes ☐ No If yes, provide a written explanation.

_____

_____

_____

6. **Have you ever been named in a civil/malpractice case related to your employment as a nurse?**

☐ Yes ☐ No If yes, provide a written explanation

Falsification of Response

I certify that the answers I have given to each and all of the foregoing questions are true to the best of my knowledge. I know that falsification of any information on this form will subject me to dismissal from the University. I further certify that I have read and understand the instructions for the completion of this application.

_____ _____

Signature Date

LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Nursing

Recommendations

Provide one of the Recommendation *in Support of Graduate Admission Application Form* and a business envelope to each of the three (3) people who have agreed to provide a recommendation for you. Request the completed form to be placed in the envelope and the recommender should seal and sign the envelope. Provide the recommender adequate time to complete and return the recommendation to you to include in your application packet. Be sure to sign each form giving the recommender permission to provide the requested information. One recommendation must be from a peer and one from a supervisor.

LSU Health New Orleans
HEALTH SCIENCES CENTER
School of Nursing

Recommendation in Support of Graduate Admission Application

Name of Applicant: _____

To the Applicant: Applicant's release of Information: I authorize the recommender to provide information related to my qualifications for admission to graduate studies. Applicant's waiver of the right to confidential statement: I hereby freely and voluntarily waive my right to access to any information contained in this recommendation and agree that the statement shall remain confidential.

Signature of Applicant Date

To the Recommender: We would appreciate a recommendation from you concerning the person named above who is applying for admission to the Graduate Program at the Louisiana State University Health Sciences Center.

_____ _____
Signature Position and Title

_____ _____
Name of Institution or Organization Department or Division

Phone Number _____

Street Address

City State Zip Code

Please respond to the following questions about the applicant.

In what primary role do you know the applicant? _____

How long have you known the applicant? _____Years _____ Months

How well do you know this applicant: _____Very Well _____ Moderately

_____Minimally _____ Not at all

How would you rate the applicant for each of the following characteristics? Please select the rating that best describes the applicant in each category. Select "not observed" if you have not had an opportunity to evaluate the characteristic or have no basis for assessment.

	Superior	Excellent	Good	Average	Below Average	Not Observed
Oral Communication: speaks clearly with precision and accuracy, without ambiguity.						
Written Communication: writing is precise, accurate, grammatically correct and unambiguous.						
Intellectual Ability: academic competence and aptitude for graduate school.						
Leadership: takes initiative and motivates others.						
Ethics: displays honesty, integrity, and ethical behaviors.						
Empathy: considerate, sensitive, and tactful in response to others.						
Reliability: dependable, responsible, prompt, and thorough.						
Clinical Judgment: displays critical thinking skills, common sense, and decisiveness.						
Interpersonal Relations: able to get along well with peers and superiors.						
Adaptability: reacts well to stress, is poised and controlled**.**						
Professional Appearance: maintains good personal hygiene, appropriate attire, well-groomed.						
Management of Tasks: Able to handle and complete multiple tasks, complete within deadlines.						
Clinical skills: Performs skills according to current standards.						

Recommendation concerning admission:

_____ I highly recommend this applicant

_____ I recommend this applicant

_____ I recommend this applicant, but with reservations*

_____ I am not able to recommend this applicant*

*** Please specify any concerns below**:

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City State Zip Code

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In what primary role do you know the applicant? _____

How long have you known the applicant? _____Years _____ Months

How well do you know this applicant: _____Very Well _____ Moderately

_____Minimally _____ Not at all

How would you rate the applicant for each of the following characteristics? Please select the rating that best describes the applicant in each category. Select "not observed" if you have not had an opportunity to evaluate the characteristic or have no basis for assessment.

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LSU Health New Orleans
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Recommendation in Support of Graduate Admission Application

Name of Applicant: _____

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_____ _____
Signature Position and Title

_____ _____
Name of Institution or Organization Department or Division

Phone Number _____

Street Address

City State Zip Code

Please respond to the following questions about the applicant.

In what primary role do you know the applicant? _____

How long have you known the applicant? _____Years _____ Months

How well do you know this applicant: _____Very Well _____ Moderately

_____Minimally _____ Not at all

How would you rate the applicant for each of the following characteristics? Please select the rating that best describes the applicant in each category. Select "not observed" if you have not had an opportunity to evaluate the characteristic or have no basis for assessment.

	Superior	Excellent	Good	Average	Below Average	Not Observed
Oral Communication: speaks clearly with precision and accuracy, without ambiguity.						
Written Communication: writing is precise, accurate, grammatically correct and unambiguous.						
Intellectual Ability: academic competence and aptitude for graduate school.						
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Empathy: considerate, sensitive, and tactful in response to others.						
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Clinical skills: Performs skills according to current standards.						

Recommendation concerning admission:

_____ I highly recommend this applicant

_____ I recommend this applicant

_____ I recommend this applicant, but with reservations*

_____ I am not able to recommend this applicant*

*** Please specify any concerns below**:

LSUHSC School of Nursing, Nurse Anesthesia Program Practice Survey

How frequently do you PERSONALLY PERFORM the following skills? (check the appropriate box)

Skill	never	Daily	2-3 times/ week	weekly	biweekly	monthly
Intravenous line insertion						
Arterial line insertion						
Arterial line monitoring						
Central line insertion						
Central Venous Pressure Monitoring						
Pulmonary Artery Pressure Monitoring						
Mixed Venous blood saturation monitoring						
Cardiac Output Monitoring						
Monitor neuromuscular						
Adjust ventilator settings						
Make ventilator weaning decisions						
Monitor during conscious sedation						
Systemic Vascular Resistance Monitoring						

How frequently do you administer the following pharamcologic agents?

Agent	Never	Daily	2-3 times/week	weekly	biweekly	monthly
Nitroglycerine infusion						
Nitroprusside infusion						
Phenylephrine infusion						
Phenylephrine bolus						
Dopamine infusion						
Dobutamine infusion						
Levophed infusion						
Epinephrine infusion						
Ephedrine bolus						
Neuromuscular blocking agents						
Sedation agents						
Intravenous narcotics						

Please tell us about your primary site of employment

How many beds are in the unit in which you currently work?	1-5 ☐		6-10 ☐		11 or more ☐	
Approximately how many hours per week are you working?	10-20 ☐	21-30 ☐	31-40 ☐	41-50 ☐	51-60 ☐	more than 60 ☐
How many beds are in the hospital in which you currently work?	1-50 ☐	51-100 ☐	101-150 ☐	151-200 ☐	201-250 ☐	>250 ☐
Characterize your hospital	Rural ☐		Surburban ☐		Urban ☐	
Type of ICU	Emergency ☐	Operating Room ☐	Post-Anesthesia recovery ☐	Medical ☐	Surgical ☐	Pediatric or Neonatal ☐
	Open-heart recovery ☐	Transitional or Step-down ☐	Neurologic ☐	Trauma ☐	Other (specify) ☐	
How long have you worked in the unit described above?	< 6 months ☐	6-12 months ☐	12-18 months ☐	18-24 months ☐	24-36 months ☐	more than 36 months ☐

LSUHealthNewOrleans
School of Nursing

VERIFICATION OF GRADUATE PRACTICUM HOURS

(Please print or type)

Name: _____ **Student ID**: _____
Last **First** **MI**

APPLICANT: Please complete Items 1-4 and send to the Program Director of the program you attended to complete.

PROGRAM DIRECTOR: Please complete Items 5 and 6 and return this form to the student or fax it to LSUHSC SON Student Affairs at 504-568-5711.

1. **Name of University**:_____

   Program Name: _____

   University Address:

   _____ _____
   Street/Box Number **City** **State** **Zip**

   University Telephone:

   _____

2. **Type of Degree Conferred/Awarded:**
   ____ Master of Nursing Degree
   ____ Master of Science in Nursing Degree
   ____ Other Master's Degree – Please specify _____
   ____ Post-Master's Certificate Program

3. **Area of Concentration**:
   _____Nurse Practitioner (specify what type) _____
   _____Nurse Anesthesia
   _____Clinical Nurse Specialist (specify what type) _____
   _____Nursing Administrating
   _____Nurse Midwife
   _____Other

4. **Date of Program Completion**: _____

5. **Total Number of Supervised Practicum Hours in Program**: _____
   Clock Hours

6. Your signature on this form attests that the above named individual has completed the program indicated on this document.

   Program Director (Print Name):_____

   Program Director Signature: _____ **Date**_____

Upon completion, please return this form to the student or to:

Stamp with School Seal