

Arkansas State University
MSN Nurse Anesthesia Application Check List

You will be mailing in *two separate packets the following information:

1. Mail the following to ASU Graduate Admissions, PO Box 1570, State University, AR 72467.
 - Graduate School Application (available on line at <http://www.graduateschool.astate.edu>)
 - Payment of \$30.00 for application fee
 - All official transcripts
Transcripts need to be sent from all colleges and Universities you have attended.
Graduate level descriptive and inferential Statistics class transcript
 - GRE Test Results (taken within last 5 years) a score of 300 is preferred (290 Minimum)
 - Proof of MMR immunization

2. Application for Nurse Anesthesia Program. Place all of the following in an envelope and mail together.
 - Completed Nurse Anesthesia Program Application (available on website)
 - Personal Resume
 - Professional Goal Statement
 - GRE Test Results
 - CCRN or CSC
 - Three Recommendations, completed and sealed by person writing the recommendation (forms are available on the website)

Mail to:
ASU, School of Nursing
Nurse Anesthesia Program
PO Box 910
State University, AR 72467

Recommendation forms are included below. 1) To be completed by a Nursing Supervisor, 2) To be completed by Academic Faculty, and 3) To be completed by your choice of a Nursing Supervisor or Academic Faculty.

All of the above requirements are needed in order to be considered for an interview.

**ARKANSAS STATE UNIVERSITY
MSN NURSE ANESTHESIA PROGRAM**

NURSE ANESTHESIA PROGRAM APPLICATION

In addition to completing the Arkansas State University Graduate School Application, (www.graduateschool@state.edu), applicants for the MSN Nurse Anesthesia Program must complete this form to be considered for admission. Please type or clearly print in black ink. **This form must be completed and returned to PO Box 910, State University, AR 72467**

1. Name _____ 2. Anticipated Enrollment Year _____
 Last Middle First

3. Phone (H) _____ (C) _____ 4. E-mail address _____

5. Mailing Address _____

6. School of Nursing _____ Date of first RN license _____

7. RN License:

License number	State	Expiration date

Has your RN license ever been suspended, restricted or revoked? Yes No

Have you ever been the subject of a nursing board disciplinary action? Yes No

Have you ever been denied a professional nursing license? Yes No

Have you ever been convicted of a felony? Yes No

Have you ever been other than a dishonorable discharge from
 any branch of the US military? Yes No

If yes, Explain _____

8. Have you ever attended another Nurse Anesthesia Program? Yes No

If yes, Explain _____

9. Professional Certification

Type of Certification	Issuing Agency	Expiration date

Note: Students are required to have current BLS, ACLS and PALS after acceptance into the program and prior to entry and to maintain current certification throughout the program.

10. Critical Care Experience:

Name of Facility	City and State	Critical Care Specialty Area List area (examples) SICU, CVICU, MICU, ICU, CCU, NICU, PICU	From-To Month/Yr	Full/Part time	Shift worked

11. Indicate your skill level in the following categories:

	Numbers Per week	Numbers per week Independently	Numbers per week with Assistance	Number of years experience	No Experience
Arterial monitoring					
Central Venous Pressure					
Swan Ganz Catheter					
Intra-aortic Balloon Pump					
Vasoactive Drugs					
Ventilators					

12. I certify that the statements that I made on the Supplemental Application Form are accurate and complete. I understand that withholding information on this form and/or the Graduate Application Form may make me ineligible for admission to the Program or subject to dismissal after acceptance into the program.

13. I authorize the program to make inquires of my employers/educational institution

Signature of Applicant: _____ Date: _____

**Arkansas State University
Nurse Anesthesia Program**

**RECOMMENDATION FORM Applicant
Evaluation by Academic Faculty**

Section one: To be completed by applicant.

Applicant:		
Last	First	Middle
Applying for class 20 _____		

I hereby voluntarily waive and relinquish any right of access to this confidential letter of Evaluation.	I retain my right of access to this letter of Evaluation.
Applicant Signature _____	Applicant Signature _____
Date _____	Date _____

Section Two: To be completed by faculty of academic institution.

Instructions: A Dean or Faculty member knowledgeable about the academic performance of the applicant is asked to complete the remainder of this form.

A. Familiarity with Applicant

1. How do you know applicant? How well do you know applicant? In what courses did you teach applicant?

2. How long have you known applicant?

B. Do you believe this applicant's academic performance is indicative of his/her intellectual ability?

- Yes No

C. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

D. Narrative comments:

Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

E. Overall Recommendation

Please check the box indication the category in which you would like to place this applicant.

- Recommend enthusiastically – upper 10 percent of applicants
- Recommend with confidence – upper one-third of applicants
- Recommend with reservation – lower one-third of applicants
- Do not recommend (please explain)

F. Evaluator's information:

Academic faculty Name: _____	
Title: _____	
Hospital/clinical facility: _____	
Mailing Address: _____	
City/State _____	Zip: _____
Phone: _____	Date: _____
Evaluator's Signature: _____	Date: _____
<p>Please return this evaluation in an official envelope directly to:</p> <p>Arkansas State University, School of Nursing, MSN Nurse Anesthesia Program, P.O. Box 910, State University, AR 72467.</p>	

**Arkansas State University
MSN Nurse Anesthesia Program**

**RECOMMENDATION FORM
Applicant Evaluation by Academic Faculty or Nursing
Supervisor**

Section one: To be completed by applicant.

Applicant:		
Last	First	Middle
Applying for class 20_____		
I hereby voluntarily waive and relinquish any right of access to this confidential letter evaluation.		I retain my right of access to this letter of Evaluation.
		Applicant Signature
Applicant Signature		Date

Section Two: To be completed by RN, CRNA or Anesthesiologist.

Instructions: To be completed by RN, CRNA or Anesthesiologist of the applicant's choosing.

Instructions: A RN, CRNA or Anesthesiologist that possesses professional knowledge of the applicant is asked to complete the remainder of this form

A. Familiarity with Applicant

1. How do you know applicant? How well do you know applicant?

2. How long have you known applicant?

B. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

C. Narrative comments:

Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

D. Overall Recommendation

Considering all of the applicants to nurse anesthesia programs that you have known, please check the box indication the category in which you would like to place this applicant.

- Recommend enthusiastically – upper 10 percent of applicants**
- Recommend with confidence – upper one-third of applicants**
- Recommend with reservation – lower one-third of applicants**
- Do not recommend (please explain)**

E. Evaluator's information:

Nursing Supervisor's Name: _____	
Title: _____	
Hospital/clinical	
Mailing	
City/State _____	/ _____ Zip: _____
Phone: _____	Date: _____
Evaluator's Signature: _____ Date: _____	
Please return this evaluation in an official envelope directly to:	
Arkansas State University, Department of Nursing, MSN Nurse Anesthesia Program, P.O. Box 910, State University, AR 72467.	

**Arkansas State University
Nurse Anesthesia Program**

**RECOMMENDATION FORM Applicant
Evaluation by Nursing Supervisor**

Section one: To be completed by applicant.

Applicant:		
Last	First	Middle
Applying for class 20_____		

I hereby voluntarily waive and relinquish any right of access to this confidential letter of evaluation.	I retain my right of access to this letter of Evaluation.
Applicant Signature	Date
Applicant Signature	Date

Section Two: To be completed by current Nursing Supervisor.

Instructions: The applicant's current Nursing Supervisor is asked to complete the remainder of this form. The Nursing Supervisor's evaluation of the applicant should be based on direct observations and knowledge of the applicant.

Hospital/Medical Center where employed: _____

City_____ State_____ Employment date: Start (___/___/___) Stop (___/___/___)

Primary unit_____ #of beds_____ Shift worked _____ Hours worked /wk. _____

Secondary unit (if any) _____ #of beds_____ Shift worked _____ Hours worked/wk. _____

A. Familiarity with Applicant

1. How do you know applicant? How well do you know applicant?

2. How long have you known applicant?

B. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

C. Applicant Clinical Experience

Please evaluate the applicant with respect to the following clinical procedures and skills by checking the appropriate column. The admissions Committee is seeking information about the applicant regarding their critical care experience and the level of competence that they possess. If applicant was not in a critical care position at the time of employment, please skip this section (D) and write a narrative in E.

	Number Managed per week	Number Managed Independently	Number Managed with Assistance	No Experience
Arterial Monitoring				
Central Venous Pressure Monitoring				
Pulmonary Artery Pressure Monitoring				
Intra-aortic Balloon Pump				
Vasoactive Drugs				
Ventilators				
Intracranial Pressure Monitoring				
Functions as Code Blue Team Leader				
Functions as Code Blue Team Member				

E. Narrative comments:

Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

F. Overall Recommendation

Considering all of the applicants to nurse anesthesia programs that you have known, please check the box indication the category in which you would like to place this applicant.

- Recommend enthusiastically – upper 10 percent of applicants
- Recommend with confidence – upper one-third of applicants
- Recommend with reservation – lower one-third of applicants
- Do not recommend (please explain)

G. Evaluator's information:

Nursing Supervisor's Name: _____	
Title: _____	
Hospital/clinical facility: _____	
Mailing Address: _____	
City/State _____	/ _____ Zip: _____
Phone: _____	Date: _____
Evaluator's Signature: _____ Date: _____	
Please return this evaluation in an official envelope directly to:	
Arkansas State University, School of Nursing, MSN Nurse Anesthesia Program, P.O. Box 910, State University, AR 72467.	

**Arkansas State University
Nurse Anesthesia Program**

**RECOMMENDATION FORM Applicant
Evaluation by Academic Faculty**

Section one: To be completed by applicant.

Applicant:		
Last	First	Middle
Applying for class 20_____		

I hereby voluntarily waive and relinquish any right of access to this confidential letter of Evaluation.	I retain my right of access to this letter of Evaluation.
Applicant Signature	Applicant Signature
Date	Date

Section Two: To be completed by faculty of academic institution.

Instructions: A Dean or Faculty member knowledgeable about the academic performance of the applicant is asked to complete the remainder of this form.

A. Familiarity with Applicant

1. How do you know applicant? How well do you know applicant? In what courses did you teach applicant?

2. How long have you known applicant?

B. Do you believe this applicant's academic performance is indicative of his/her intellectual ability?

- Yes No

C. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

D. Narrative comments:

Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

E. Overall Recommendation

Please check the box indication the category in which you would like to place this applicant.

- Recommend enthusiastically – upper 10 percent of applicants
- Recommend with confidence – upper one-third of applicants
- Recommend with reservation – lower one-third of applicants
- Do not recommend (please explain)

F. Evaluator's information:

Academic faculty Name: _____	
Title: _____	
Hospital/clinical facility: _____	
Mailing Address: _____	
City/State _____	Zip: _____
Phone: _____	Date: _____
Evaluator's Signature: _____	Date: _____
<p>Please return this evaluation in an official envelope directly to:</p> <p>Arkansas State University, School of Nursing, MSN Nurse Anesthesia Program, P.O. Box 910, State University, AR 72467.</p>	

REPORT OF MEDICAL HISTORY

To the Student: Information you provide will have no effect upon your admission to University. It will be used solely as an aid in providing necessary health care while you are a student.

This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent.

SEX M F

Last Name (Print) First Name Middle

Home Address (Number and Street) City or Town State Zip Code Date of Birth

Name, Relationship, and Address of Next of Kin Home Telephone Number

Next of Kin's Business Address Business Telephone Number

Marital Status Citizenship

S M

Class you are entering

Do you have medical insurance? Yes ___ No ___

Name of Company (A student insurance plan is available in Office of Student Affairs)

Immunization Completed	Date last injection		Have you had any of the following?				Relationship
	Yes	No	Tuberculosis	Diabetes	Kidney Disease	Heart Disease	
Tetanus							
Diphtheria							
Small Pox							
Mumps							
Rubella							
Polio							
Typhoid							
Other							

PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS Comment on all positive answers in space below or on additional sheet

Have you had?	Yes No		Insomnia	Yes No		Chest Pain/Pressure	Yes No		Gallbladder Trouble
	Yes	No		Yes	No		Yes	No	
Scarlet Fever									
Measles									
German Measles									
Mumps									
Chicken Pox									
Malaria									
Gum or tooth Trouble									
Sinusitis									
Eye Trouble									
Ears, Nose, Throat Trouble									
Surgery									
Appendectomy									
Tonsillectomy									
Hernia Repair									
Other									

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous or emotional condition or personality or character disorder?		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians, heaters, or other practitioners within the past five years? (Other than routine check-ups?)		
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons)		
G. Do you have any questions in regard to your health, family history, or other matter, which you would like to discuss now with a member of the staff of the Health Services?		

REMARKS OR ADDITIONAL INFORMATION

Comments on any items checked "Yes" above
(Use additional sheet if necessary)

Student's Signature

Date