ARKANSAS STATE UNIVERSITY

DOCTORATE OF NURSING PRACTICE (DNP) APPLICATION

1. Legal Name *

2. Other names that appear on academic records (enter names in full)

3. Year

2014

4. Mailing Address *

5. Permanent Address

6. Home Phone

7. Mobile Phone

8. E-mail Address *

9. List state(s) in which you have an active RN license and include State, License Number and Expiration Date

10. List state(s) in which you have an active license as an Advanced Practice Nurse and include State, License Number and Expiration Date

11. Have you received any discipline regarding any licensure in any jurisdiction?

- Yes
- No

12. If yes, please provide information

13. Submit Transcripts to the ASU Graduate School *
Please include Institution, Completed Date of Master's degree

14. Graduate Level Statistics Course with Institution, Grade, Date Completed (Transcript must also be submitted to ASU Graduate School)*

15. Verification of Master's Degree Precepted Graduate Clinical Hours

☐ Clinical hours reported on official transcript

☐ Notarized letter from school attesting to the number of supervised clinical hours completed.

16. Nursing Experience as an Advanced Practice Nurse

List all nursing employment in chronological order, beginning with the most recent. Include Position and Clinical Area, Agency, and Location (City and State)

17. Please list potential clinical agencies where you plan to acquire clinical hours in the DNP Program. Include Name of Agency, Contact Person, and Address.

CAREER GOALS

18. Please describe your career goals in <450 words (Word, Times New Roman/12/DS).

19. Briefly describe your ideas for a capstone project

20. Have you been convicted of a felony?

- Yes
- No

21. If yes, provide an explanation

-MM- / -DD- / -YYYY-

Evidence must be provided to the School of Nursing of the following (25-31). Send to awaters@astate.edu

22. Current CPR (American Heart Association for Professionals) - Expiration Date

-MM- / -DD- / -YYYY-

23. TB Screening - Last Screening Date

-MM- / -DD- / -YYYY-

24. Hepatitis B (Shot 1) - Completion Date

-MM- / -DD- / -YYYY-

25. Hepatitis B (Shot 2) - Completion Date

-MM- / -DD- / -YYYY-

26. Hepatitis B (Shot 3) - Completion Date

-MM- / -DD- / -YYYY-

-MM- / -DD- / -YYYY-

27. Health Insurance - Expiration Date

-MM- / -DD- / -YYYY-

28. GRE Scores and Date Taken

29. By checking this box, I certify that I have carefully considered each question and that my statements are true and complete to the best of my knowledge. I authorize Arkansas State University to contact the colleges, universities, and employers indicated in my application and accompanying materials to verify the accuracy of anything contained in the application and accompanying material. Further, I understand that I will not be eligible for admission if any information is found to be incomplete or inaccurate *

☐ I Agree

30. Your Name *

31. Date *