BAYONNE MEDICAL CENTER SCHOOL OF NURSING
COOPERATIVE NURSING PROGRAM
APPLICATION

INSTRUCTIONS: Send this form with a check or money order for $40.00 to the School of Nursing. All applicants must also submit a Hudson County Community College application.

Applicants to the above named program are selected in accordance with nondiscriminatory practices.

Social Security Number: _____ Today's Date: _____

Last Name: _____ First Name: _____ MI: ____

Home Address: _____
Number and Street City State Zip

Home Telephone Number: _____ Cell Telephone Number: _____

E-Mail Address_____

Person to notify in case of emergency: _____ Number: _____

Hudson County Community College Student _____ **OR** HCCC Application & $15.00 Fee Attached _____

Have you previously applied for admission to this Nursing School? (yes) (no) If yes, date: _____

Have you previously attended any other Nursing School? (yes) (no) If yes, dates: _____

Are you currently a Licensed Practical Nurse? (yes) (no) If yes, give your license number: _____

Have you ever been convicted of a felony or misdemeanor? (yes) (no) If yes, please explain: _____
_____
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_____

Employment History: List all work experiences, both full and part-time since high school. Begin with most recent.

Dates	**Title/Position**	**Employer**	**City and State**

Three Professional or Educational references are required. (See reference forms)

Continued →→→→

Please write a brief account of your strengths and weaknesses, career aspirations, reasons for selecting nursing as a career and any other reasons you have for choosing to enter this program.

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I am aware that, if accepted to the Bayonne Medical Center School of Nursing, I will be required to agree to a criminal background investigation. I further understand that commencement and continuation in the School of Nursing program is contingent upon the satisfaction of Bayonne Medical Center School of Nursing, in its sole and total discretion, with the results of this criminal background investigation. A criminal history background check is a pre-requisite for licensure in the State of New Jersey.

I certify to the best of my knowledge that the information is correct and that falsification of information may subject me to dismissal.

Your Signature: _____ Date: _____

Send this directly to the School of Nursing. Application fee is non-refundable and non-transferable.

Bayonne Medical Center School of Nursing
69-71 New Hook Road
Bayonne, New Jersey 07002