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

Please read this page and the enclosed brochure before beginning the application process.

Applicants are accepted into the practical nursing program on a first come, first served basis. Each class has a limited number of students, who are accepted in order of completion of the application process. 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 program start date. All requirements must be met by the posted 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 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 high school transcript, diploma or their GED Certificate. 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 Certification Exam prior to acceptance into the LPN program. This qualification will be verified with the Illinois Department of Public Health CNA 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 $55.00 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 $55.00 testing fee must be paid each time. The test consists of four parts—Math, Reading, English, and Science. You must 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 a 54% in English, along with a score of 40.4% in Science must 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

The physical examination form must be completed by a physician or nurse practitioner. The TB test or chest x-ray and required lab tests must be current **within twelve (12) of admission** into the program. The 5-panel drug screen must be completed upon enrollment. All immunization information MUST include dates of immunization, dates of titers, or documented history of the disease. TB must remain current throughout the program. At least the first two steps of the Hepatitis B vaccine must be completed for admission with step 3 completed as scheduled.

REFERENCE LETTERS

Three references are required, preferably from employers or coworkers using the forms enclosed. Do not submit references from family members or in-laws. References **should not** be submitted before personal information and personal health forms have been sent.

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 a background check is clear or waiver received. A rapid 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.

BLS CPR certification for Healthcare Providers through the American Heart Association is required before entering the program. CPR 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 after October 1st of each year. 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

$55 fee due one week prior to date of test Date: _____
Photo ID required for entrance to testing site

HIGH SCHOOL DIPLOMA/TRANSCRIPT OR GED CERTIFICATE/TRANSCRIPT

Diploma/Transcript or GED Certificate/Transcript submitted Date: _____

PHYSICAL EXAM FORM/PROOF OF IMMUNIZATIONS SUBMITTED

Physical Exam performed by Healthcare Professional Date: _____
Immunizations
2 Step PPD or Chest X-Ray within 12 months Date: _____
Rubella Titer or Vaccination Date: _____
Rubeola Titer or Vaccination Date: _____
Mumps Titer or Vaccination Date: _____
Hepatitis B Titer or Vaccination Date: _____
(at least Steps 1 & 2 completed)
Varicella Titer or Vaccination or Date: _____
Healthcare Provider documentation of the disease
5-panel Drug Screen Date: _____

REFERENCES

Three Reference forms submitted (no relatives) Date: _____

CPR

Current Healthcare Provider CPR Card submitted Date: _____

CNA CERTIFICATION

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

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, references or physical exam forms.

CLASS DESIRED: February_____Year_____August _____Year_____

NAME:_____
Last First Middle Maiden

ADDRESS:_____
Street City State Zip Code County

TELEPHONE:_____**ALT/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.

EMERGENCY CONTACT: Name_____Phone_____Relation_____

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.

Female___Male___Date of birth_____Place of birth (City, State, Zip) _____

Marital Status: Single_____Married _____Separated_____Divorced_____Widow_____

Number of children: _____Ages_____

Ethnicity: Black (Non-Hispanic)_____American Indian or Alaskan Native_____Hispanic_____

Asian or Pacific Islander___White, Anglo, Caucasian (Non-Hispanic)___Other (Specify)_____

How did you hear about us?_____

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

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

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, Zip)	Dates Of Employment
Name Of Employer	Address (Street, City, State, Zip)	Dates Of Employment
Name Of Employer	Address (Street, City, State, Zip)	Dates Of Employment

(List other employers on a separate page.)

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 or sexual orientation.

REV. 5/17

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_____ M.I. _____ SUFFIX (JR., SR.) _____

MAIDEN NAME OR OTHER ALIASES_____

SOCIAL SECURITY NUMBER _____/_____/_____

DATE OF BIRTH_____/____/_____ SEX: MALE____ FEMALE_____
Month Day Year

RACE: WHITE BLACK ASIAN HISPANIC PACIFIC ISLANDER UNKNOWN

DRIVERS LICENSE #_____ STATE ISSUED_____

CURRENT ADDRESS_____
Street Address

_____ _____ _____
City State Zip

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_____

Print Full Name_____

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_____

REFERENCE FORM

APPLICANT NAME: _____

The above named applicant has applied for admission to the Capital Area School of Practical Nursing. He/she has given your name as a reference. Your candid comments concerning the applicant's personal characteristics and potential for success as a Practical Nurse will be appreciated. The Practical Nurse functions as a member of the health-care team under the direction of the licensed registered nurse, physician, dentist or podiatrist. The Practical Nurse is accountable for his/her own nursing actions and competencies.

PLEASE RATE THE APPLICANT ON THE FOLLOWING CHARACTERISTICS:

CHARACTERISTIC	EXCEEDS Expectations	MEETS Expectations	BELOW Expectations	N/A	COMMENTS
Personal Appearance					
Sincerity of Purpose					
Emotional Stability					
Dependability					
Attendance					
Health					
Initiative					
Ethical					
Honesty					
Ability to adjust to new people					
Ability to adjust to new situations					
Ability to accept criticism					
Ability to organize work					
Interpersonal Communication Skills					
Ability to function as a member of the Health-care Team					
Reaction to Stressful Situations					

How long have you known this applicant? _____

In what relationship do you know the applicant? _____

If you are, or have been an employer, please give dates of employment:_____

What qualities does the applicant have that you think would contribute to her/his success as a Practical Nurse?

Please give any further information that you have about this applicant that will help us decide on her/his suitability for Practical Nursing.

Signature_____ Date_____

Printed Name_____ Position, if employed_____

Please return this form as soon as possible to:

Capital Area School of Practical Nursing
2201 Toronto Road
Springfield, IL 62712-3803
Fax 217-585-2165

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Dependability					
Attendance					
Health					
Initiative					
Ethical					
Honesty					
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Ability to adjust to new situations					
Ability to accept criticism					
Ability to organize work					
Interpersonal Communication Skills					
Ability to function as a member of the Health-care Team					
Reaction to Stressful Situations					

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Emotional Stability					
Dependability					
Attendance					
Health					
Initiative					
Ethical					
Honesty					
Ability to adjust to new people					
Ability to adjust to new situations					
Ability to accept criticism					
Ability to organize work					
Interpersonal Communication Skills					
Ability to function as a member of the Health-care Team					
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Signature_____ Date_____

Printed Name_____ Position, if employed_____

Please return this form as soon as possible to:

Capital Area School of Practical Nursing
2201 Toronto Road
Springfield, IL 62712-3803
Fax 217-585-2165

Capital Area School of Practical Nursing

Student Physical Examination Form

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

Date_____

Name :First, Middle Initial, Last:	
DOB:	
Street Address:	
City:	
State and Zip Code:	
Home Phone:	
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 use of alcohol and/or drugs:

TO BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER

General Appearance:				
Height	Weight	B/P	Pulse	Respirations
Date of last visual exam:	Vision: Right	Vision: Left	Corrective Lenses: R	Corrective Lenses: L

Check the appropriate boxes below:

Physical Findings	Normal	Abnormal	Describe Abnormality (Use separate sheet if needed)
Ears, Nose & Throat			
Mouth, Teeth			
Thyroid			
Heart & Vascular			
Lungs			
Abdomen			
Neck & Vertebrae			
Extremities			
Skin			
Neurological			

Medication taken on regular basis or as needed:

Date Started	Medication	Dosage	Route	Indications

ALL OF THE BELOW ITEMS ARE REQUIRED BEFORE ADMISSION

5-Panel Drug Screen:

Date:	Drug Name:	Negative:	Positive:
	Marijuana		
	Cocaine		
	Amphetamines		
	Opiates		
	PCP		

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		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:

This student has had a complete physical, can complete the essential functions, and is in satisfactory physical/mental condition to care for infant, child, and adult patients in an actual hospital/clinical setting.	Yes	No
If no, why not?		

Health Provider's Name:	Title:
Health Provider's Signature:	Date:
Health Provider's Address:	Phone Number:

Class 122: February 6, 2018 to December 14, 2018

P = Instructor Prep Day; I, II, III, IV = First Day of Quarter;
H = No School; L = Lab Day; C = Clinical Day; X = End of Quarter;
XX = Graduation Ceremony m/u = Attendance Make Up Day

Capital Area School of Practical Nursing

2201 Toronto Road
Springfield, Illinois
62712

First Quarter
36 Theory
12 Clinical

Second Quarter
29 Theory
18 Clinical

Third Quarter
29 Theory
18 Clinical

Fourth Quarter
30 Theory
18 Clinical

REVISED 5/2/17

February

S	M	T	W	T	F	S
4	P	I	7	8	9	10
11	12	13	14	15	16	17
18	H	20	21	22	23	24
25	26	27	28			

March

S	M	T	W	T	F	S
				1	2	3
4	H	L	7	8	9	10
11	L	L	14	15	16	17
18	L	L	C	C	C	24
25	26	27	C	C	H	31

April

S	M	T	W	T	F	S
1	H	H	H	H	H	7
8	9	10	C	C	C	14
15	16	C	C	C	C	21
22	23	X	E	H	H	m/u
29	II					

May

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	L	L	23	24	25	26
27	H	L	30	31		

June

S	M	T	W	T	F	S
					1	2
3	4	C	C	C	C	9
10	11	C	C	C	C	16
17	L	C	C	C	C	23
24	25	C	C	C	C	30

July

S	M	T	W	T	F	S
1	2	C	H	H	C/X	m/u
8	H	H	H	H	H	14
15	H	H	H	H	H	21
22	P	III	25	26	27	28
29	L	L				

August

S	M	T	W	T	F	S
			C	C	C	4
5	6	7	C	C	C	11
12	13	14	C	C	C	18
19	20	21	C	C	C	25
26	27	28	C	C	C	

September

S	M	T	W	T	F	S
						1
2	H	4	C	C	C	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	X	E	m/u
30						

October

S	M	T	W	T	F	S
	H	IV	3	4	5	6
7	H	9	C	C	C	13
14	15	16	C	C	C	20
21	22	23	C	C	C	27
28	29	30	C			

November

S	M	T	W	T	F	S
				C	C	3
4	5	6	C	C	C	10
11	H	13	C	C	C	17
18	19	20	H	H	H	24
25	26	27	28	29	30	

December

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	m/u
9	10	11	12	X	XX	15

"To provide quality educational opportunities for students to develop the knowledge, skills, and attitude necessary to succeed and advance in the nursing profession serving a culturally diverse community in a variety of healthcare settings."