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 class. All requirements must be met at least 14 days prior to the class start date. Applications are kept on file for one year after submission. After 1 year, all documents expire, including the application fee. No refunds are given for the Application or TEAS test 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, but the application 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. The applicant's **current** name must be indicated on all transcript(s).

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 in advance. No MONEY WILL BE ACCEPTED THE DAY OF THE EXAM. The test may be attempted three (3) times; however, the $55.00 testing fee must be paid each time. The test consists of four parts—Math, Reading, English and Language Usage, and Science. A passing score of 54% must be attained in each area tested, except Science which must be 40.4%. Study guides are available. Tests must be scheduled in advance by the Admission Specialist.

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 the year of admission** into the program. All immunization information MUST include dates of immunization 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 and proof returned to the Admissions Specialist.

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.

CPR certification in either American Heart Association's Healthcare Provider or Professional Rescuer through American Red Cross is mandatory before entering the program. No On-Line CPR courses will be accepted. CPR must remain current throughout the program.

Please notify the Nursing Office if there is any change in your personal information (name, address or phone number) during the application process.

FINANCIAL AID

All students that intend to apply for Financial Aid must complete a FAFSA as soon as possible after January 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, applicants will be placed on the roster for the next available class. Applicants will receive a letter informing them of their placement on a class roster. 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 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: ______________________________
  - Hepatitis B Vaccination (at least Steps 1 & 2 completed) Date: ______________________________
  - Varicella Vaccination, Titer or Healthcare Provider documentation of the disease Date: ______________________________
- 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 (Complete and pass State of Illinois Cert) 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 before you send transcripts, references or physical exam form.

Class Desired: February__________Year_________August _____________Year_________

Name____

Last First Middle

Maiden

Address____

Street City State Zip Code County

Telephone________________Alt/Cell Number_________________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**
- ☐ No, I am not a citizen or eligible non-citizen.

REGISTRATION #

Next Of Kin: Name__________________________Phone___________________Relation_________________

Address____

Street City State Zip Code

Education: (Give Name, City And State Of Each School. Use Back Of 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__________________

How Would You Describe Yourself? Black (Non-Hispanic)______American Indian or Alaskan Native______Hispanic________

Asian or Pacific Islander___White, Anglo, Caucasian Nonhispanic_____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.)

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 Nurse Administrator 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 on 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.09/09,1/11,1/17

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 inquires 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. S/he 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 professional 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, ILLINOIS 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:

History: Include any significant information regarding previous medical, surgical, psychiatric conditions and use of alcohol and/or drugs:

Physical Exam Form

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

Physical Exam Form

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

MEASLES (Rubeola) 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. Two are required. First immunization with live attenuated virus given after 1957 and on or after first birthday. Second dose separated by 28 days or more.	Date of first immunization	Date of second immunization

HEPATITIS B. Titer required when no vaccination records available	Date of first immunization
Date of blood titer (HBsAb or anti-HBs):	Date of second immunization
Quantitative Result:	Date of third immunization:

Tuberculosis: Nursing students must have a 2 step TB testing			
Step 1: PPD Date:		Step 1: PPD Results	
Step 2: PPD Date:		Step 2: PPD Results	

Chest X-Ray within the last year	Date	Results

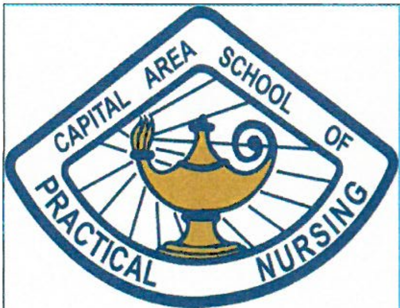
VARICELLA (CHICKEN POX) Two doses 30 days apart or more OR blood titer		
Date of first dose	Date of second dose	Blood titer results

RUBELLA (GERMAN MEASLES) Select option 1 or 2 and provide requested documentation.	
Option 1. First immunization with live attenuated virus. (Given after 1957 and given on or after student's first birthday).	
Date of immunization: OR	
Option 2. Date of blood titer:	
Quantitative Results of blood titer:	

SEASONAL INFLUENZA VACCINATION **Per Clinical sites policy/procedures**	
Date:	

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 121: August 22, 2017 to June 22,2018

P=Prep Day; I, II, III, IV=First Day of Quarter; H=Holiday; L=Lab Day; C=Clinical Day; X= End of Quarter; I= instructor in-service E=Emergency Day XX=Graduation Ceremony

Capital Area School of Practical Nursing
2201 Toronto Road
Springfield, Illinois 62712
217-585-1215

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 11 / 16 / 16

August

S	M	T	W	T	F	S
	P	I	23	24	25	26
27	28	29	30	31		

September

S	M	T	W	T	F	S
					1	2
3	H	L	6	7	8	9
10	L	L	13	14	15	16
17	L	L	C	C	C	23
24	25	26	C	C	C	30

October

S	M	T	W	T	F	S
1	2	3	C	C	C	7
8	H	10	C	C	C	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	X	E				

November

S	M	T	W	T	F	S
			H	II	3	4
5	6	7	8	9	H	11
12	13	14	15	16	17	18
19	20	21	H	H	H	25
26	27	L	29	30		

December

S	M	T	W	T	F	S
					1	2
3	L	L	C	C	C	9
10	11	12	C	C	C	16
17	H	H	H	H	H	23
24	H	H	H	H	H	30
31						

January

S	M	T	W	T	F	S
	H	2	C	C	C	6
7	L	9	C	C	C	13
14	H	16	C	C	C	20
21	22	23	C	C	C	27
28	X/P	III	31			

February

S	M	T	W	T	F	S
				1	2	3
4	L	L	C	C	C	10
11	12	13	C	C	C	17
18	H	20	C	C	C	24
25	26	27	C			

March

S	M	T	W	T	F	S
				C	C	3
4	H	6	C	C	C	10
11	12	13	C	C	C	17
18	19	20	21	22	23	24
25	H	H	H	H	H	31

April

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	X	14
15	IV	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May

S	M	T	W	T	F	S
		1	C	C	C	5
6	7	8	C	C	C	12
13	14	15	C	C	C	19
20	21	22	C	C	C	26
27	H	29	C	C		

June

S	M	T	W	T	F	S
					C	2
3	4	5	C	C	C	9
10	11	12	13	14	15	16
17	18	19	20	X	XX	23
24	25	26	27	28	29	30

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