

APPLICATION CHECKLIST

DEADLINES: July 1 for Fall, November 1 for Spring, March 1 for Summer

The following items are required for application to Beth-El College of Nursing and Health Sciences MSN program:

- Graduate Application Part I
- Graduate Application Part II
- In-state Tuition Classification Sheet (must be filled out and signed, even if not claiming)
- Application Fee \$60.00 (make checks payable to UCCS)
- Transcripts: Two (2) official copies sent to us direct from **each** and **every** college institution attended.
- Documentation of Undergraduate Required Course Work (Statistics, Health Assessment, and Research)
- Copy of RN unrestricted license (from the state in which you are licensed to practice)
- Recommendation Letters (4 required)
- Resume documenting at least one years' recent (within five years) nursing work experience
- Official documentation of 2 MMR vaccinations or titer showing immunity to each of the three diseases (exempt from this requirement if born before 1/1/57), HepB series or titer showing immunity, 2 Varicella vaccinations, titer or history of chickenpox, current annual TB skin test or normal chest x-ray report if unable to take test, and current Tetanus vaccination.

*Please note that ALL items listed above are required for admission and packets will not be considered complete until **all** items are received.*

Current CPR, Health Insurance, and Malpractice Insurance at the student NP level will be required **before** clinical/practicum hours begin, and must be maintained throughout your practicum experience.

The GRE test is NOT required for admission to the MSN program.

Send all materials to:

**Diane Busch c/o
UCCS/Beth-El College of Nursing
1420 Austin Bluffs Pkwy
Colorado Springs, CO 80918**

Once all items have been received your packet will be sent to the Admissions committee for review and decision and you will be notified by letter. Final admissions will be contingent upon a criminal background check at cost to student. If admission is approved, background check information will follow.

If you have questions regarding requirements, please call:

Diane Busch
Program Assistant
(719) 255-4424 or 1-800-990-8227 (x4424)
dbusch@uccs.edu

Age, Birth Date, and Birthplace:

Birth Date:

Birthplace: City and State

Birthplace: Country

Sex: Male Female

Ethnicity (for compliance with the 1964 Civil Rights Act):

- African American or Black, not of Hispanic origin
 - American Indian or Alaskan Native
 - Asian or Pacific Islander
 - Hispanic, Chicano, Mexican American, or Latino
 - White, not of Hispanic origin
 - I do not wish to provide this information.
 - Multiracial-indicate other ethnic or racial terms that further or better describe your ethnic background.
-

Citizenship

- U.S. Citizen
- Non-U.S. Citizen on Permanent Status - Country of citizenship _____
 Alien registration no. _____
 Date of issue _____
- Nonimmigrant on temporary status - Country of citizenship _____
 Type of visa you now hold or expect to obtain Student (F-1) Exchange Visitor (J-1) None
 Other (specify) _____

For what major are you applying? NURS **Major Department Code:** NG-NURS

Degree: MSN Special Field: _____
Specify ANP, FNP, AGNP, or ACS

Check here if you are applying as a CATECS student

Have you ever applied for graduate status at the University of Colorado? No Yes
When? _____

At any other CU campus? No Yes
When? _____ What department? _____

Are you enrolled in another graduate degree program at the University of Colorado? No Yes
What program, campus, and department? _____
Do you plan to complete that program? No Yes

Admission Type:

- First time in a master's program
- Previously enrolled in a master's program
- First time in a doctoral program
- Previously enrolled in a doctoral program

For which term are you applying?

- Fall 20 ____ (begins late August) Springs 20 ____ (begins mid-January) Summer 20 ____ (begins late May or early June)

List in chronological order all undergraduate and postbaccalaureate schools attended or being attended, including the University of Colorado; indicate whether semester (S) or quarter (Q) hours. CALCULATE YOUR GRADE POINT AVERAGE. Consider A as 4 points, B as 3, C as 2, D as 1, F as 0. (Your exact average will be calculated before final action is taken by the Graduate School.) Attach an additional sheet if necessary.

Undergraduate List All School Name, City and State Zip Code (required)

	Dates of Attendance	Date and Degree Conferred	Overall Grade Point Average	Office use only	Overall Grade Point Average		
					Hours	Points	Average
1.					___	___	___
2.					___	___	___
3.					___	___	___
4.					___	___	___
5.					___	___	___

Postbaccalaureate List All

School Name, City and State	Zip Code (required)	Dates of Attendance	Date and Degree Conferred	Overall Grade Point Average			Office use only
				Hours	Points	Average	
1.					___	___	___
2.					___	___	___
3.					___	___	___

GPA Undergraduate

GPA Postbaccalaureate

List Below all courses in progress including extension and correspondence courses:

School Name:

Course Title and Number	Credit Hours	Estimated Grade
1.		
2.		
3.		
4.		
5.		

Last attendance at University of Colorado (semester, year, school):

Have you ever received credit for any work done at the University of Colorado? No Yes

If yes, campus or locations:

Have you ever been convicted of a felony? No Yes (If Yes, attach an explanation.)

Are you or have you ever been in the Armed Forces of the United States? No
When? _____

I have read the instructions, and hereby certify that to the best of my knowledge the information furnished on this form is true and complete. I understand that if found to be otherwise, it is sufficient cause for refusal or dismissal.

Applicant's Signature: _____ Date: _____

APPLICANT DO NOT WRITE BELOW THIS LINE

- Admit Regular for _____ degree _____ major code
- Recommend admit provisional for _____ degree _____ major code
- Refuse Admission

Signature of Department Officer

Department

Date

University of Colorado at Colorado Springs

**Application for Admissions Part 2
Graduate Nursing Department**

A few tips: This form can be printed out as it is and then filled in by hand, or you can tab through the form fields (which should be gray), type in the information on-screen, and then print after. Use additional sheets if necessary. In either case, a final printed copy with a signature in ink is necessary.

Applicant's Legal Name (do not use nicknames or initials)

Last

First

Middle

The Department you are applying for is the MSN/Graduate Nursing Program

- 1. List the names and addresses of the four references you have asked to submit a "request for recommendation" on your behalf. Be sure to select references who are in a position to comment competently on your probability of success in graduate work.**
 - a.**
 - b.**
 - c.**
 - d.**
- 2. List your non-academic, industrial or professional experience from start of undergraduate work to present, including dates.**
- 3. List any honor societies and learned professional societies of which you are a member, and positions held.**
- 4. List any scholarships, prizes, honors, or other recognitions, and, where applicable, their duration and amount.**
- 5. Please define what nursing is to you in 200 words or less. Use an additional sheet if necessary.**

6. **Please describe what modifications you will need to make in your life in order to allow you to be successful in the graduate nursing program.**

Questions 7-17 should be answered by a Yes or No

7. **Has any nursing or other health care license held by you been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited or placed on probation in any state or territory of the United States?**
- yes no
8. **Are you under investigation or is a disciplinary action pending against your nursing or other health care license in any state or territory of the United States?**
- yes no
9. **Have you received notification from the Department of Health and Human Services, Office of the Inspector General, that you have been excluded from participation in Medicare, Medicaid and federal health care programs?**
- yes no
10. **Have you been convicted, entered a plea of guilty, nolo contendere or not contest for any felony, misdemeanor or petty offense? (The fact that a conviction have been pardoned, expunged, dismissed, deferred, or that your civil rights have been restored does not mean that you answer “no”, you should answer “yes”.**
- yes no
11. **Has any final judgment, settlement or arbitration award for malpractice been paid by your or on your behalf?**
- yes no
12. **Do you have a physical or mental disability which renders you unable to perform nursing services or duties with reasonable skill and safety and which may endanger the health and safety of persons under your care?**
- yes no

For questions 15, 16 and 17, you may answer “NO” if you have signed a contract with the State Board of Nursing’s Impaired Professional Diversion Program know has the Colorado Nurse Health Program (CNHP). The CNHP is authorized to evaluate and monitor nursing licensees experiencing drug, alcohol, and psychological problems.

13. Are you now or have you been addicted to any controlled substance, a regular user of any controlled substance without a prescription or habitually intemperate in the use of intoxicating liquor?

yes no

14. Has your use of any controlled substance, habit forming drug, prescription medication, or alcohol resulted in a negative consequence for you? (For example, loss of employment, arrest for DUI, arrest for prescription fraud, health problems, etc).

yes no

15. Have you been arrested for an alcohol or drug-related offense?

yes no

FOR ADVANCED PRACTICE NURSES ONLY:

16. Have your clinical privileges at any hospital or health care facility been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished?

yes no

FOR ADVANCED PRACTICE NURSES WITH PRESCRIPTIVE AUTHORITY

17. Has you DEA registration been under investigation, denied, restricted, surrendered, voluntarily relinquished or expired or have you entered into a Memorandum of Understanding (MOU)?

yes no

In accordance with sections 18-8-503 and 18-8-501(2)(a)(1), C.R.S., false statements made herein are punishable by law. I state under the penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statues, that the information contained in this application is true and correct to the best of my knowledge. I understand that providing false information is grounds for denial, suspension or dismissal from the graduate nursing program.

Date _____ Applicant’s Signature _____

BETH-EL COLLEGE OF NURSING AND HEALTH SCIENCES

UNIVERSITY OF COLORADO AT COLORADO SPRINGS

REQUIRED UNDERGRADUATE COURSES

Applicant Name:

Please complete the following items indicating your required undergraduate course work. This will become part of your application record.

COURSE	COURSE #	COURSE NAME	INSTITUTION	SEM/ YEAR	CREDIT	GRADE
STATISTICS						
HEALTH ASSESSMENT						
NURSING RESEARCH						
Pathophysiology <i>(RN-MSN students only)</i>						
Community Health Nursing <i>(RN-MSN students only)</i>						

1. If any or all content of any of the above listed courses were included in another course (i.e. Adult Nursing, Nursing Process) a course description is required.
2. Please contact your prior school/university to have the course description sent to you for your application process.
3. Complete this form and return it with your application.

I certify that the above listed information is true and correct and follows all standards of ethical and moral conduct in content.

Signature

Date

THE GRADUATE SCHOOL REQUEST FOR RECOMMENDATION

University of Colorado at Colorado Springs

The applicant should complete all of Section I and the mailing instructions at the end of the form. One form should be given to each recommender.

Section I. To be completed by the applicant

Last (Family) Name	First Name	Middle	Maiden Name (optional)
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is applying for admissions to a Graduate School of the University of Colorado and has listed you as a reference on his or her application for graduate work toward a MS in NURSING.

To the applicant: Under the Family Educational Rights and Privacy Act of 1974, students who are admitted and who matriculate into the program to which they apply are given the right to inspect their records, including their letters of recommendation, unless they have waived their right to review. You have the option of (1) signing the following waiver or (2) declining to do so.

1. I expressly waive any rights I might have to access to this letter of recommendation under the Family Educational Rights and Privacy Act of 1974.

Signature _____ Date _____

2. I do not agree to the waiver above.

Signature _____ Date _____

Section II. To the recommender:

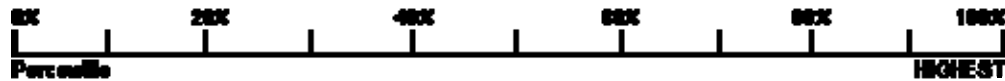
This form is intended solely for your convenience; its use is optional. Before you agree to submit a recommendation, whether on this form or on your own stationery, please review the reference to the federal law entitled the Family Educational Rights and Privacy Act of 1974 as presented above in our instructions "To the applicant".

We solicit your candid evaluation of the applicant's preparation for graduate study, range of abilities and accomplishments, and creative and intellectual promise. **On the back of this form, or on your own stationery, please summarize your opinion of (a) the quality of the applicant's academic or creative achievements, including material not apparent on the official transcripts; (b) the applicant's scholarly or creative potential and promise for advanced and original work; (c) those aspects of the applicant's personality and character significant to graduate study; and (d) the applicant's special skills and experience where demonstrated in an art, vocation, or profession. We would appreciate knowing the extent of your contact with the applicant and any special opportunities you may have had to observe him or her.**

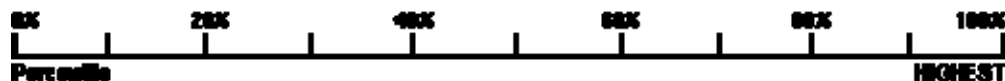
Section III. Summary Evaluation

Compared with the _____ (number) students you have known in the past _____ years in his or her field at approximately the same level of training, this student would rank as indicated on the scales below, when evaluated for:

a) Scholarly or creative achievement



b) Promise or probability of success



Note: The educational level of the representative group with whom the applicant is compared is:

- | | |
|--|--|
| <input type="checkbox"/> College Seniors | <input type="checkbox"/> Terminal-Year Graduate Students |
| <input type="checkbox"/> First-Year Graduate Students | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Intermediate-Year Graduate Students | |

Recommender's Signature: _____ Date _____

Name Printed or Typed _____ Title _____

Address: _____

**RECOMMENDER PLEASE
RETURN THIS FORM TO:**

**BETH-EL COLLEGE OF NURSING & HEALTH SCIENCES
UNIVERSITY OF COLORADO AT COLORADO SPRINGS
PO BOX 7150 UH-1
COLORADO SPRINGS, CO 80933-7150
Attn: Graduate Nursing**

THE GRADUATE SCHOOL REQUEST FOR RECOMMENDATION

University of Colorado at Colorado Springs

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 Last (Family) Name First Name Middle Maiden Name (optional)

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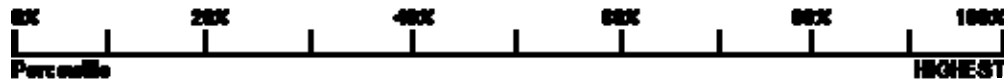
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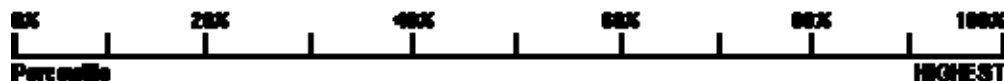
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- | | |
|--|--|
| <input type="checkbox"/> College Seniors | <input type="checkbox"/> Terminal-Year Graduate Students |
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| <input type="checkbox"/> Intermediate-Year Graduate Students | |

Recommender's Signature: _____ Date _____

Name Printed or Typed _____ Title _____

Address: _____

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**BETH-EL COLLEGE OF NURSING & HEALTH SCIENCES
UNIVERSITY OF COLORADO AT COLORADO SPRINGS
PO BOX 7150 UH-1
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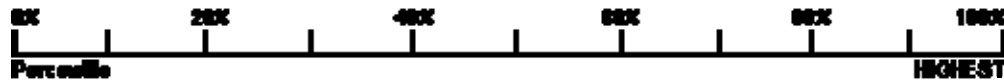
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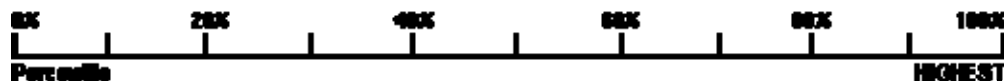
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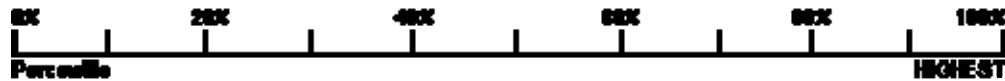
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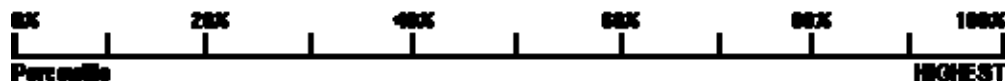
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|--|--|
| <input type="checkbox"/> College Seniors | <input type="checkbox"/> Terminal-Year Graduate Students |
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| <input type="checkbox"/> Intermediate-Year Graduate Students | |

Recommender's Signature: _____ Date _____

Name Printed or Typed _____ Title _____

Address: _____

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UNIVERSITY OF COLORADO AT COLORADO SPRINGS
PO BOX 7150 UH-1
COLORADO SPRINGS, CO 80933-7150
Attn: Graduate Nursing**

Requirements for all Beth-El College of Nursing & Health Sciences MSN students:

1. Colorado State law requires certified proof of two (2) MMR vaccinations or written evidence of laboratory tests showing titers of all three diseases (measles, mumps and rubella). This is not required if born before January 1, 1957. The student must also provide copy to UCCS Student Health Center prior to registering for classes. Contact the Student Health Center at (719) 255-4444 or fax info to (719) 255-4446. Failure to have this on file with the Student Health Center can result in registration being blocked by Admissions & Records.
2. Varicella series (2 vaccinations), titer showing immunity, or history of chicken pox or shingles documented by a healthcare provider.
3. Hepatitis B series (3 vaccinations) or titer showing immunity.
4. Proof of current annual TB skin test or chest x-ray with explanation if unable to take test.
5. Proof of current Tetanus vaccination.

Items 1-5 are required for admission to the program, items 6-9 required prior to beginning your practicum or health assessment clinical, usually in your second year.

6. Proof of current CPR certification
7. Proof of Health Insurance
8. Proof of Malpractice Insurance at the student NP level with an expiration date visible

Send copies to:

Diane Busch c/o
UCCS/Beth-El College of Nursing & Health Sciences
1420 Austin Bluffs Pkwy
Colorado Springs, CO 80918

Or Fax to:
(719) 255-4496, Attn: Diane Busch

Indicate the term for which you are claiming in-state status:

Fall 20__ (begins late August) Spring 20__ (begins mid-January)

Summer 20__ (begins early June or early July)

1. Are you a citizen of the United States? Yes No If not, are you a permanent resident? Yes No

2. List your most recent employers.

	Employer	City	State	From (Mo./Day/Yr.)	To (Mo./Day/Yr.)
#1	_____	_____	_____	____/____/____	____/____/____
#2	_____	_____	_____	____/____/____	____/____/____

3. Did you graduate from a Colorado high school? Yes No

Name of School _____ City _____

Date of Graduation (mo./yr.) ____/____/____

4. List all institutions of higher education you have attended. Attach an additional page if necessary.

Names of Institutions of Higher Education (First Attended to Last)	City	State	From (Mo./Day/Yr.)	To (Mo./Day/Yr.)
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

5. Parent/guardian name, relationship, address, and employment

Name: _____ Relationship: Parent Guardian Spouse

Street Address or P.O. Box: _____

City: _____ State: _____ Dates: ____/____/____ to ____/____/____

Most Recent Employer:

City: _____ State: _____ Dates: ____/____/____ to ____/____/____

For informational purposes, the phrase "your family" in the terms below designates your

Parent Guardian

6. Dates of continuous physical residence in Colorado (mo./day/yr.)

YOU

____/____/____ to ____/____/____

NA

YOUR FAMILY

____/____/____ to ____/____/____

NA

7. Dates of absences from Colorado of more than two months in duration within the past two years (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA YOUR FAMILY _____ / ____ / ____ to _____ / ____ / ____ NA
8. Dates of employment in Colorado (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA YOUR FAMILY _____ / ____ / ____ to _____ / ____ / ____ NA
9. List exact years for which personal resident Colorado income tax returns were filed
 YOU _____ NA YOUR FAMILY _____ NA
10. Dates of active duty military service (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA YOUR FAMILY _____ / ____ / ____ to _____ / ____ / ____ NA
- 10a. Dates stationed in Colorado (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA YOUR FAMILY _____ / ____ / ____ to _____ / ____ / ____ NA
11. Dates you/your family member have had a Colorado driver's license (mo./day/yr.)
 _____ / ____ / ____ NA
- Issue date of previous Colorado license, if applicable (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA
12. List exact years of Colorado motor vehicle registration
 YOU _____ NA YOUR FAMILY _____ NA
13. Give state in which currently registered to vote
 YOU _____ NA YOUR FAMILY _____ NA
- Dates of Colorado voter registration (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA YOUR FAMILY _____ / ____ / ____ to _____ / ____ / ____ NA
14. Dates of ownership of a home in Colorado that is your/your family member's primary residence (mo./day/yr.)
 YOU _____ / ____ / ____ to _____ / ____ / ____ NA YOUR FAMILY _____ / ____ / ____ to _____ / ____ / ____ NA
15. Are your parents separated or divorced? Yes No NA

I hereby certify that to the best of my knowledge the information furnished on this form is true and complete without evasion or misrepresentation. I understand that if found to be otherwise, it is sufficient cause for refusal or dismissal and may result in legal action.

Applicant's Signature: _____ Date: _____

