OZARKS TECHNICAL COMMUNITY COLLEGE
ASSOCIATE of SCIENCE in NURSING PROGRAM
APPLICATION

Date Fee Paid_____
Receipt # & Initials_____
Office Use Only

Mail or bring the completed application and $15 fee (**nonrefundable**) to:
Ozarks Technical Community College, Allied Health Office**,** 1001 East Chestnut Expressway, Springfield, MO 65802-3625

Application Deadline: March 1st – Classes start in August

NAME			
	Last:	First:	Mi:
All Previous Last Names Used:			
Social Security Number:	- -		
ADDRESS			
	Street Number & Name:		
City:		State & Zip Code:	
Home Phone # & Cell Phone #:		Work Phone #:	
May A Message Be Left At These Numbers:	O Yes O No	Email Address:	
EDUCATION	*Note High School graduation or G.E.D. Equivalency is required		
High School Education	Name:	City & State:	Years Attended:
Did You Graduate?	O Yes O No	If Yes, When? (Month & Year)	
G.E.D. Information	Year Obtained:	City:	State:
Practical Nursing Program	Name Of School:	City:	State:
Dates Of Attendance:		Did You Graduate? O Yes O No If No, Are You Currently Attending Or Plan To Attend PN School? O Yes O No	
Month & Year Of Graduation:			

College/University Information	Indicate Below All College, Universities, Vocational Programs Previously Attended			
Name	State	Dates Of Attendance	Major	Graduation Date

Employment	List All Jobs You Have Had In The Past Five Years, **Beginning With The Most Recent; Use Additional Page If Needed**		
Employer	Position Held	Dates Of Employment	Reason For Leaving

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief and hereby grant the school permission to verify such answers. I understand that any false statement on this application may be considered as sufficient cause for rejection or dismissal. I understand that acceptance into and the completion of this program does not guarantee permission to sit for the State Board Test for licensing (Missouri Nursing Practice Act Statue Chapter 335). Please note that applicants from non-English speaking countries must submit evidence of English language proficiency. **I also understand that my application will not be considered complete until all required documentation has been received by the Allied Health office of OTC.**

Signature _____ Date _____ **3/18/09**