**Capital Area Career Center**

**Capital Area School of Practical Nursing (CASPN)**

**2201 Toronto Road ▪ Springfield, IL ▪ 62712-3803**

**Phone (217) 585-1215 ▪** [**http://caspn.edu/**](http://caspn.edu/)

***Please read this page before beginning the application process.***

Applicants are accepted into the practical nursing program on a **first come, first served basis**. Each class is limited to sixty-five (65) students, who are accepted in order of completion of the admission requirements. 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 designated application 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 **Application** must be completed and returned with a $75.00 application fee online before applications will be processed. Applicants may take the pre-entrance (TEAS) examination after these items are submitted. However, the application process is not complete until **all** documents on the Admissions Checklist are received.

Applicants must provide an official copy of their high school or GED **transcript**. High school transcripts **must be from a state-recognized and accredited institution**. Home schooled students or online secondary education credentials are not recognized. Applicants with these forms of Secondary education completion credentials will be required to complete one of the approved high school equivalency exams (GED®, HiSET®, or TASC™).

Applicants must have completed a state approved CNA program **AND** passed the Illinois CNA Certification Exam prior to acceptance into the PN program. The CASPN Admissions Office will verify this qualification with the Illinois Department of Public Health, Health Care Worker Registry.

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.

# 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 $65.00 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 $65.00 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 through the Adult Education Secretary.

# Viewpoint Screening service

Viewpoint Screening is a service to aid you in keeping track of your required documents for admissions. The physical form, drug screen, all required immunization information, background check, and BLS CPR Card **must be submitted through Viewpoint Screening.**

**The next page has a checklist for you to keep track of everything you need to upload.**

BLS CPR certification for Healthcare Providers through the American Heart Association is required before entering the program. **CPR must remain current throughout the program**.

To reach Viewpoint Screening visit <https://www.viewpointscreening.com/caspn>

# FINANCIAL AID

All students that intend to apply for Financial Aid must complete a FAFSA as soon as possible. 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](http://www.FAFSA.ed.gov) Our School Code is **016426**.

# Capital Area School of Practical Nursing Admissions Checklist (For your Records)

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 (completed online)

Application and $75 application Fee Date:

## Pre-Entrance (ATI TEAS) Exam Scheduled

$65 fee due one week prior to date of test Date Scheduled:

Photo ID required for entrance to testing site

## High School Transcript or GED Transcript

1. Applicants must provide an **official high school or GED transcript**. High school transcripts **must be from a state-recognized and accredited institution**. Home schooled students are required complete one of the approved high school equivalency exams (GED®, HiSET®, or TASC™) Date:

## **Physical Form/immunizations/drug screen/Cpr submitted to viewpoint screening**

* Physical Exam performed within last 12 months

 *(Signed by a Healthcare Professional)* Date Uploaded:\_\_\_\_\_\_\_\_\_\_

* TB Test: 2 Step PPD, Chest X-Ray or Quantiferon

 *(within the last 12 months)* Date Uploaded:\_\_\_\_\_\_\_\_\_\_

* MMR Vaccine OR Date Uploaded:\_\_\_\_\_\_\_\_\_\_
	+ Rubella Titer or Vaccination Date Uploaded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Rubeola Titer or Vaccination Date Uploaded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Mumps Titer or Vaccination Date Uploaded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Tdap Vaccine *(within last 10 years)* Date Uploaded:\_\_\_\_\_\_\_\_\_\_
* Hepatitis B Titer or Vaccination *(At least steps 1 & 2 completed)* Date Uploaded:\_\_\_\_\_\_\_\_\_\_
* Varicella Titer or Vaccination Date Uploaded:\_\_\_\_\_\_\_\_\_\_
* COVID-19 Vaccine and Booster Date Uploaded:\_\_\_\_\_\_\_\_\_\_
* Flu Vaccine (Sept.-Mar.) Date Uploaded:\_\_\_\_\_\_\_\_\_\_
* 10-panel Drug Screen Lab report Date Uploaded:\_\_\_\_\_\_\_\_\_\_
* Current BLS Provider CPR Card issued

by **The American Heart Association** Date Uploaded:\_\_\_\_\_\_\_\_\_\_

## cNA Certification

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

**Verified by CASPN Admissions Office**

**The next 3 pages must be uploaded to Viewpoint as your Physical…**

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**Phone (217) 585-1215**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  Name |  |
| DOB |  |
| Street Address |  |
| City, State, Zip |  |
| 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:

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

|  |
| --- |
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**Are you currently pregnant? \_\_\_\_\_\_\_\_\_\_ If yes, when is your due date? \_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Date:**

**TO BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| General Appearance:  |
| Height | Weight | B/P | Pulse | Respirations |
|  |  |  |  |  |

**Check the appropriate boxes below:**

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Findings | Normal | Abnormal | Describe Abnormality (Use separate sheet if needed) |
| Eyes, Ears, Nose & Throat |  |  |  |
| Endocrine |  |  |  |
| Cardiovascular |  |  |  |
| Respiratory  |  |  |  |
| Gastrointestinal |  |  |  |
| Musculoskeletal |  |  |  |
| Extremities |  |  |  |
| Skin |  |  |  |
| Neurological |  |  |  |
| Mental Health |  |  |  |

**Medication taken on regular basis or as needed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date Started | Medication | Dosage  | Route | Indications |
|  |  |  |  |  |
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**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Essential Functional Abilities of the Nursing Student**

*Each student must have a complete physical examination and have their healthcare provider initial each section and sign at the bottom of this form prior to entering the program.*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Issue | Examples of Necessary Activities    Not all-Inclusive | Standard |
| **Mobility**Reviewed by\_\_\_\_\_\_\_\_\_\_\_*initials* | Move from place to place independently, maneuver to perform nursing activities, move in small spaces, perform CPR, lift 50 pounds and exert up to 100 pounds force to push/pull.  Able to bend, squat, kneel, twist, reach above shoulder level and climb stairs. Able to stand for extended periods of time | Physical abilities to sufficiently care for patients in small spaces and move from room to room. |
| **Motor Skills**Reviewed by\_\_\_\_\_\_\_\_\_\_\_*initials* | Perform manual psychomotor skills by maintaining balance in standing and sitting positions, hand and finger coordination allowing the student to grasp, twist, pinch and squeeze.  Able to position patients, use hands repetitively, travel to/from academic sites. Able to complete electronic documentation | Gross and fine motor skills sufficient to provide safe and effective care. |
| **Hearing**Reviewed by\_\_\_\_\_\_\_\_\_\_*initials* | Hear monitor alarms, pump alarms, call bells, intercom, emergency alarms, auscultatory sounds, and patient’s or visitor’s call for help. | Auditory ability sufficient for monitoring and assessing health needs. |
| **Visual**Reviewed by\_\_\_\_\_\_\_\_\_\_\_*initials* | Observe patient for multiple needs:  Skin assessment, wound assessment, color changes, medication administration.  Able to read the information on a computer screen. Depth perception. | Visual ability sufficient for observation, assessment and documentation for safe nursing care. |
| **Communication**Reviewed by\_\_\_\_\_\_\_\_\_\_\_*initials* | Interact with others, speak, write and understand English at a level to effectively communicate with patients as well as report and document patient information.  Understand flow charts, graphs to interpret data and enter date. Read and understand digital and computer displays. Initiate health teaching. | Abilities sufficient for verbal, nonverbal and written communication with patients, families and other healthcare providers. |
| **Emotional Stability**Reviewed by\_\_\_\_\_\_\_\_\_\_\_*initials* | Interact and support patients during times of stress and emotional upset, adapt to changing and emergency situations while maintaining emotional control, manage patients with strong emotions and physical outburst while remaining in a reasonably calm state, deal with numerous interruptions and multiple demands while still completing tasks | Stable emotional stateto care for patients with strong emotional situations, ensuring patient safety. |

**I certify that the above named student has been examined by me. This student is found to be in good physical and mental health as outlined above.  I have determined that this student may participate in laboratory, lecture and clinical experiences with NO restrictions.**

Healthcare Provider Signature: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name and Title:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_