

**Southern Illinois University Edwardsville School of Nursing**  
**Graduate Program in Nursing**  
**Application for Admission to Post-Master's Doctor of Nursing Practice Program**

**Directions: Please complete the following items. Completion of this form certifies that all information provided is valid and accurate:**

**Name:** \_\_\_\_\_  
Last First Middle Maiden

**Address (Home)** \_\_\_\_\_  
Street City State Zip

**County:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Work Phone: \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Years practicing (RN)** \_\_\_\_\_ **Years practicing (APN) if applicable** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Gender:** Female Male

**Date of anticipated admission to program:**

Fall Semester (Year) \_\_\_\_\_

**Which of the following graduate degrees have you earned?**

\_\_\_\_ Family Nurse Practitioner      \_\_\_\_ Post-Master's Family Nurse Practitioner  
\_\_\_\_ Health Care and Nursing Administration      \_\_\_\_ Post-Master's Health Care and Nursing Administration  
\_\_\_\_ Nurse Anesthesia      \_\_\_\_ Post-Master's Nurse Anesthesia  
\_\_\_\_ Other graduate degrees (please specify) \_\_\_\_\_  
\_\_\_\_ Other Post-Master's certificates (please specify) \_\_\_\_\_

**Are you nationally certified as a:**

\_\_\_\_ NP (if yes, specify your area of specialization) \_\_\_\_\_  
\_\_\_\_ CNS (if yes, specify your area of specialization) \_\_\_\_\_  
\_\_\_\_ Nurse Midwife  
\_\_\_\_ CRNA  
\_\_\_\_ Nursing Management/Administration  
\_\_\_\_ Other (please specify) \_\_\_\_\_

**What is your national certification body?**

\_\_\_\_ ANCC      \_\_\_\_ AONE      \_\_\_\_ ACNM  
\_\_\_\_ AANA      \_\_\_\_ NAPNAP      \_\_\_\_ Other (please specify) \_\_\_\_\_  
\_\_\_\_ AANP      \_\_\_\_ AMCB

**Are you currently practicing in your area of specialization?** \_\_\_\_ Yes \_\_\_\_ No

**What is your current practice role?**

\_\_\_\_\_

**Name and address of current employer:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you interested in completing your required practice experiences in the DNP program at your current site of employment?

\_\_\_\_\_Yes \_\_\_\_\_No

**Professional Nursing Licensure: (Attach copies of all RN licenses.)**

**Type of Nursing License:** \_\_\_RN license \_\_\_APN license

Illinois: # \_\_\_\_\_ Date of Expiration \_\_\_\_\_

Missouri: # \_\_\_\_\_ Date of Expiration \_\_\_\_\_

Other: (Please specify State) \_\_\_\_\_ # \_\_\_\_\_ Date of Expiration \_\_\_\_\_

Other: (Please specify State) \_\_\_\_\_ # \_\_\_\_\_ Date of Expiration \_\_\_\_\_

**Education**

Please list all institutions attended since high school, starting with the most recent. Identify dates attended and degrees (if earned).

**ASSOCIATE DEGREE/DIPLOMA EDUCATION (IF APPLICABLE):**

Name of School	City and State	Dates Attended	Degree/date of graduation (if applicable)

**BSN/BACCALAUREATE EDUCATION:**

Name of School	City and State	Dates Attended	Degree/date of graduation (if applicable)

**MASTER'S IN NURSING/(ALSO MASTER'S IN OTHER DISCIPLINE IF APPLICABLE)**

Name of School	City and State	Dates Attended	Degree/date of graduation (if applicable)

**DOCTORAL COURSEWORK/DEGREE (IF APPLICABLE):**

Name of School	City and State	Dates Attended	Degree/date of graduation (if applicable)

**DNP Courses Completed (for consideration of transfer into the program)**

Course Number and Title	School	Date	Grade	Credit Hours

**Prerequisite Courses**

Course	School	Course Number	Date Completed	Credit Hours	Grade
Graduate-level Statistics					
Graduate-level Epidemiology					
Graduate-level course in Evidence-Based Practice (or equivalent professional experience)					

**Professional Experience** (list all professional employment, start with the most recent).

<b>Institution</b>	<b>City and State</b>	<b>Position Held</b>	<b>Dates of Employment</b>

**Membership** in professional organizations and honorary societies and offices held:

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**Professional** recognition and creative activity (List scholarships, honors, or recognition received. Also list publications, research, etc.)

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**References:**

Three references from past or current professors, supervisors, or professional colleagues are required. You must use the forms included with the application. The references should attest to your potential for success in the DNP program (including leadership, initiative, and competency in practice) and your commitment to the profession.

Please list the names and addresses of three individuals who will provide references.

**PLEASE PRINT OR TYPE:**

#1. Name & Credentials \_\_\_\_\_

Title \_\_\_\_\_

Health Care Facility/Institution: \_\_\_\_\_

Phone # \_\_\_\_\_

#2. Name & Credentials \_\_\_\_\_

Title \_\_\_\_\_

Health Care Facility/Institution: \_\_\_\_\_

Phone # \_\_\_\_\_

#3 Name & Credentials \_\_\_\_\_

Title \_\_\_\_\_

Health Care Facility/Institution: \_\_\_\_\_

Phone # \_\_\_\_\_

Please return this form along with your completed Project Proposal Form, 3 completed Reference Forms (in sealed envelopes) and official copies of all transcripts, to:

Southern Illinois University Edwardsville  
Graduate Admissions  
Campus Box 1047  
Edwardsville IL 62026-1047