Monroe Community College
STATE UNIVERSITY OF NEW YORK

Application to the Practical Nursing Program

Thank you for your interest in the LPN program at Monroe Community College! The LPN program is a 12-month program with 1100 hours of clinical, lab, and classroom hours. Students must maintain attendance in classroom/lab/clinical, prove competency in LPN skills, and maintain a minimum of 80% grade in each course to continue to the next quarter. Each applicant should consider many factors, to include:

1. As a clock hour program, attendance is mandatory.
2. Each student should plan for 2 hours of outside study, homework, or other to every one classroom and lab hour.
3. Flexibility is required to accommodate the completion of required hours. Please review your personal schedule to assure that this works for you and your family.

Admissions Requirements

To apply for the Practical Nursing Program applicants must:

- Have proof of a United States high school transcript or GED transcript
- Proof of US Citizenship or legal status allowing enrollment in program
- Be at least 18 years old to obtain a New York State Practical Nursing license.
- Obtain a 41 or higher in each section of the Test of Essential Academic Skills (TEAS) test
- Submit a professional application packet to the program (required documents listed below)
- Attend a mandatory informational workshop

Application Process and Required Documents

1. **Professional resume and application**. Must be typed - nothing handwritten will be accepted.
    - A Microsoft Resume Template can be used.
2. **Copy of high school transcript or GED transcript**
3. **Two (2) letters of reference**: The letters must include a signature and be sent from your reference directly to the program manager, Kelsey Klopfer (kklopfer@monroecc.edu). Please make sure that your reference puts your name in the subject line.
   (**Note:** If a candidate has attended training programs at MCC, performance in that program will be considered when selecting candidates to the LPN program.)
4. **TEAS test scores**
    a. Must be within 1 year
5. **Documentation for testing accommodations**
6. Attend a mandatory informational workshop
7. Complete and submit the provided Health Release form (attached below)
8. List of Immunizations

Acceptance

Selections are based on the following criteria and subject to available seats:

1. TEAS test scores
2. Review of submitted material

The admissions team of instructors and administration will consider the applicant's TEAS test scores and the required documents in order to make the best selections for admission into the program.

Preparing to Apply

Resources, such as a study guide and outline practice test (TEAS 7), can be purchased directly through Assessment Technologies Institute (ATI) (https://www.atitesting.com/teas/study-manual).

In addition, TEAS test preparation workshops are offered at MCC. This is an optional set of workshops designed to improve reading comprehension, review scientific knowledge, and enhance math skill. Instruction in test taking strategies and effective study sills is included. Taking this course does not guarantee placement in the PN program. Please visit the Licensed Practical Nurse Program (LPN) webpage (https://campusce.monroecc.edu/monroecc/course/course.aspx?C=873) to access workshop schedule.

ATI Launch

To better prepare students for the content and rigor of an LPN program, MCC offers ATI Launch an online asynchronous course. Throughout the 6 weeks prior to the start of the LPN program, students will gain a greater foundation in the content areas of Math, Science, and English, as well as study and test taking strategies. Students will get a feel for the structure and rigor of an LPN program to better inform their choice to enroll and their plan for success. Students must complete all work and pass ATI Launch to move forward in the program.

Medical Clearance (Health Release Form)

Medical clearance must be obtained in order to participate in this training program. This immunizations/ blood work verification requirement is indicated on the authored physical examination form and ***must*** be completed by a physician.

Tuition Payments/Costs

The LPN program is a non-credit program, and does not qualify for traditional forms of Financial Aid. Grant funding opportunities may be available for qualified applicants.

Important

Please submit hard copies of all material together in a paper folder in the following order:

- Application (see below)
- Professional Resume
- Copy of HS transcript or GED transcript
- TEAS test report, that includes test scores for each individual section.
- Health Release (see below)
- List of Immunizations

Note: The two (2) letters of reference must include a signature and be sent from your reference directly to the program manager, Kelsey Klopfer (kklopfer@monroecc.edu). Please make sure that your reference puts your name in the subject line.

Completed applications can be mailed to:

Monroe Community College
ATTN: Kelsey Klopfer
321 State Street
Office 638D
Rochester, NY 14608

Or handed in at:

321 State Street
Office Suite 638
Rochester, NY 14608

Monroe Community College
STATE UNIVERSITY OF NEW YORK

LPN Program Application

Name: _____ Cell: _____

E-mail: _____ Emergency Phone: _____

Address: _____

Education: HSD _____ GED _____ High School Name: _____

Current Employer: _____ Title: _____

Is your employer supportive of your interest in enrolling in an LPN program? _____

Attached Documents

- ☐ HS Transcript/GED
- ☐ Resume
- ☐ TEAS test results
- ☐ Health Release form
- ☐ List of Immunizations

Name of References:

1. _____
2. _____

Please initial in the space provided:

- ☐ I understand that this is a 12-month program that may require flexibility to schedule clinical, lab, and classroom experiences.
- ☐ I understand that I am only able to miss a maximum of 30 hours of classroom/lab/or clinical throughout this 12-month program and that all time is to be made up in order to complete the program.
- ☐ If I am selected, I will commit to completing all work assigned and required and that I agree to take the NCLEX within 90 days of completing the program.

I attest that all of the information provided is accurate to the best of my knowledge:

_____ _____

Name (Acknowledgement Signature) Date of Acknowledgement

Application Questions

1. What motivated you to pursue a career as an LPN?

2. What do you believe are the most important qualities an LPN should possess, and how do you embody these qualities?

3. What do you consider your academic weaknesses? How do you address them?

4. Can you tell me about a difficult work situation and how you overcame it?

5. Can you share a specific experience where you demonstrated effective communication skills, especially in a healthcare setting?

6. How do you handle stressful situations, and how would you manage the stress associated with LPN program?

7. Please describe your support system that will help you successfully complete this program.

_____ _____

Name Date

Economic Development & Innovative Workforce Services
MONROE COMMUNITY COLLEGE

Practical Nursing Program Health Release Form

Completion of this form is required to participate in the clinical portion of the Certified Nurse Assistant Training Program. Please complete all sections, front and back, and be sure you sign and date where it's requested. Your physician or health care provider needs to complete the Physician/Health Care Provider Section.

All entries made need to be in ink.

Section 1: To Be Completed by Individual

Name: _____ Date of Birth: _____ SS#: _____

Address: _____

Cell Number: _____ Alt. Number: _____ Emergency Contact: _____

Section 2: To Be Completed by Physician or Health Care Provider or Provide Record

Immunizations required for all medical programs for clinical participation.

PPD Skin Test or T-Spot: Date PPD Given: _____ (MM/DD/YY) Date PPD Read: _____ (MM/DD/YY) PPD Result: _____ POS*/NEG

*Positive PPD, chest X-ray results: Date: _____ (MM/DD/YY) Chest X-ray Result: ◯ Normal ◯ Abnormal

_____ _____

Healthcare Provider Signature/Stamp if no copy attached (PPD) **Date Healthcare Provider Signed (PPD)**

MMR (Mumps, Measles, Rubella): MMR Vaccine #1 _____ (MM/DD/YY) MMR Vaccine #2 _____ (MM/DD/YY)

Or Positive MMR Blood Titer: Measles _____ (MM/DD/YY) Mumps _____ (MM/DD/YY) Rubella _____ (MM/DD/YY)

_____ _____

Healthcare Provider Signature/Stamp if no copy attached (MMR) **Date Healthcare Provider Signed (MMR)**

Influenza Vaccine: ☐ **Copy attached**

COVID-19 – provide card for proof: ☐ **Copy attached**

Section 3 Only: Physician or Health Care Provider

Carefully read the following statement, and check the appropriate box.

Based on my medical evaluation, to the best of my knowledge, this individual is free from physical or mental impairments which might interfere with his or her ability to participate in the Licensed Practical Nurse Program.

◯ **Yes** ◯ **No**

If No is checked, please identify those problems which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel. If applicable, please indicate **Pregnancy Restrictions.**

_____ _____ _____

Physician's/Health Care Provider's (with Title) Signature **Print Physician's/Health Care Provider's Last Name/Stamp** **Date Physician/Health Care Provider Signed**

Signature here is for Section 3 only.

Section 4: Student & /or Provider Complete This Section

1. **Meningitis Vaccine:** [Note: ACIP recommends all first-year college students up to 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday.]

   a. Meningitis Vaccine #1 _____ Meningitis Vaccine #2 _____
   OR
   b. I have reviewed the **information regarding meningococcal disease online (https://www.health.ny.gov/publications/2168/) and in print in the health office, or at Health Services webpage (https:/www.monroecc.edu/depts/stuhealth/health-program-students/).** I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease. I understand this does not prevent me (my child) from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

   _____ _____
   Student (or parent of a minor student) Signature (Meningitis) Date Student Signed (Meningitis)

2. **Hepatitis B Information:**
   I understand that due to my occupational exposures to blood I may be at risk of acquiring Hepatitis B virus Infection. I did receive the Hepatitis B immunizations. Please enter dates of each dose below. If you are in the middle of receiving the series please check the box to decline and sign and date where appropriate. Continue to send in the dates as they are received.

   Hepatitis B Dose #1 _____

   Hepatitis B Dose #2 _____

   Hepatitis B Dose #3 _____

   OR Decline the vaccine at this time; I understand that by declining I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood and wish to be vaccinated, I can receive the vaccines from my physician or the health care agency that employs me.

   _____ _____
   Student (or parent of a minor student) Signature (Hepatitis B) Date Student Signed (Hepatitis B)

3. **Varicella Vaccine (Chicken Pox):** Varicella Vaccine #1: _____ (MM/DD/YY) Varicella Vaccine #2: _____ (MM/DD/YY)

   OR Date of Positive Varicella Titer: _____ (MM/DD/YY)

   OR Date of Varicella Disease: _____ (MM/DD/YY)

   OR

   I have reviewed the information regarding varicella disease available online (https://www.cdc.gov/chickenpox/vaccination.html). I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against varicella disease. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

   _____ _____
   Student (or parent of a minor student) Signature (Varicella) Date Student Signed (Varicella)

4. **TD or TDAP:** TD/TDAP Vaccine #1 _____ (MM/DD/YY, Administered within 10 years)

   OR

   I have reviewed the information regarding diphtheria vaccines available online (https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html). I understand the risks of not receiving the vaccine. I have decided that I will not obtain the TDAP immunization. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620. Phone 585-753-5150.

   _____ _____
   Student (or parent of a minor student) Signature (TD/TDAP) Date Student Signed (TD/TDAP)

Return To: Monroe Community College, Workforce Development /Healthcare, Email: Kelsey Klopfer (kklopfer@monroecc.edu)
321 State Street., Office 638D, Rochester, NY 14623