Division of Health Professions
General Program Application

PROGRAM:

- ☐ Medical Coding (applications accepted continuously)
- ☐ Nursing Assistant (applications accepted continuously)
- ☐ Practical Nursing (applications due on the 2nd Friday in March for fall admission and on the 1st Friday in October for spring admission)
- ☐ Phlebotomy (applications accepted continuously)
- ☐ Radiologic Technology (applications due on the 2nd Friday in April)
- ☐ Respiratory Care Therapy (applications due on the 3rd Friday in March)
- ☐ Surgical Technology (applications due on the 2nd Friday in April)

ADMISSION REQUIREMENTS:

Complete all SEARK College Admission Requirements and general requirements listed below:

1. Completion of all general admission procedures of the College.
2. Completion of competency testing in Reading with a minimum score as listed below **OR** completion of a course in Developmental Reading with a grade "C" or better.
   - ACT**:** 19
   - Accuplacer Reading: 75
   - Compass Reading: 83
   - Next Generation Accuplacer: 251
3. Current CPR Certification (American Heart Association Basic Life Support (BLS) Provider or American Red Cross Profession Rescuer).

ACCEPTANCE PROCEDURE:

Should qualified applicants exceed the available slots in the program, admission into a class will be based on the date of completed application. Upon acceptance into the Program, the student must submit the following to begin classes: The cost of the subscription Drug Screen, and Criminal background check is the student's expense.

1. Functional Ability Acknowledgement Form
2. P.P.D. Skin Test or Chest X-Ray
3. Tdap Vaccination (**Must be taken within 10 years**)
4. Current Flu Vaccination
5. Hepatitis B Series or Signed Vaccination Waiver Claim Form.
6. Drug Screen
7. Criminal Background Check

The above information must be submitted to:

Southeast Arkansas College
Division of Nursing and Allied Health
1900 Hazel St., Pine Bluff, AR 71603
Email: nahapps@seark.edu (email applications from SEARK student email)

Students enrolled in Allied Health programs with a clinical component will be assessed a fee for malpractice insurance.

Revised: 11/28/2023

SOUTHEAST ARKANSAS COLLEGE NURSING & ALLIED HEALTH APPLICATION

NAME____

ADDRESS____

CITY____

STATE and ZIP____

DATE OF BIRTH__________________ SEX: ☐ MALE ☐ FEMALE

STUDENT I.D. #__________________PHONE NO.__________________

PERSONAL EMAIL ______________________________________

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

NAME	**ADDRESS**	**CITY/STATE**	**PHONE NO**
1.			
2.			

Do you have hospitalization or health insurance coverage? ☐ YES ☐ NO

PREVIOUS WORK EXPERIENCE (list current employer).

EMPLOYER	**CITY/STATE**	**JOB TITLE**	**FROM**	**TO**

EDUCATION:

Highest Grade Completed ________________________

Date of Graduation or GED ___________________________

Name & Location of Last School Attended: ____

Have you ever been enrolled in any other school of nursing or other allied health educational program? ☐ YES ☐ NO

If yes, please submit transcript from school of nursing.

Are you currently certified in any allied health area? ☐ YES ☐ NO

List Certification: __________________

Has your certification ever been encumbered? ☐ YES ☐ NO

If Yes, List Reasons and Dates of All Encumbrances

____

TRAVEL TO CLINCAL SITES:

Are you willing to go to any agency in our service area for your clinical training? **This may be up to 60 miles from the institution.** ☐ YES ☐NO

If no, why not: ____

FUTURE PLANS:

Plans After Graduation: ____

PERSONAL REFERENCES (No relatives)

NAME	COMPLETE ADDRESS	PHONE NUMBER
1.		
2.		

CRIMINAL BACKGROUND:

***Have You Ever Been Convicted of a Crime? ☐ YES ☐ NO**

If yes, explain: ____

*Conviction of certain crimes may cause the applicant to be ineligible to do clinical at some clinical sites. This ineligibility may result in suspension from the program.

DRUG SCREENING:

Random drug screening may be utilized at any time during the program at the student's expense.

RELEASE OF INFORMATION:

I authorize the college to release information provided by me in application for admission to the requested program to approval/accrediting agencies and clinical affiliates, as required. This authorization includes the release of my transcript.

CERTIFICATION:

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misrepresentations or a falsification of information is cause for denial of admission or suspension from the program.

________________________________ ________________________________

Date

Signature (submission from SEARK email will suffice as signature)