



TRUMAN MEDICAL CENTERS

Better. For Everyone.

School of Nurse Anesthesia Enrollment Application

2301 Holmes Street, Kansas City, MO 64108

816-404-1100

For School Use Only! Do not complete this section...

Overall GPA

ICU Experience

Organic
Chemistry

Science GPA

GRE Score

Have you
previously
applied to our
program?

Yes
No

If yes, what year?

Have you
previously
applied to any
nurse
anesthesia
program?

Yes

No

If yes, what year?

If yes, name of
program, city,
and state:



PERSONAL INFORMATION

Last Name

First Name

MI

Street Address

City

State

Zip Code

Daytime Phone
Number

Business
Phone Number

Social Security
Number

Email Address

Citizenship

Date Available to
Begin Course

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name

Relationship

Address

Daytime Phone
Number

Alternate
Phone Number



EMPLOYMENT HISTORY AND EXPERIENCE

Current
Employer

Address

Phone Number

Position

Supervisor

Unit

Date started

**List all employers since graduation from School of Nursing.
Complete mailing address must accompany each entry.**

Name of
Employer

Address

Unit & Position

Full Time

Part Time

Dates
From-To

Name of Employer

Address

Unit & Position

Full Time

Part Time:

Dates
From-To

Name of Employer

Address

Unit & Position

Full Time

Part Time

Dates
From-To

Name of Employer

Address

Unit & Position

Full Time

Part Time

Dates
From-To



EDUCATION/LICENSING

Complete mailing address must accompany each entry

High School

Address

Dates attended

through

Diploma/Degree

School of
Nursing

Address

Dates Attended

through

Diploma/Degree

Other College

Address

Dates Attended

through

Diploma/Degree

Other

Address

Dates Attended

through

Diploma/Degree

Director of
School of
Nursing

School of
Nursing

Nursing Registration (Provide copy of all RN cards and any on-line verification of expiration date.)

State/States

Number/
Numbers

Expiration Dates

Professional
Organization
Membership

Community/
Volunteer
Service

MISCELLANEOUS

Special Experience-laboratory, certifications and dates, etc.
Provide copies of each listed.

REQUIRED

ACLS Expiration
Date

BLS Expiration
Date

PALS Expiration
Date

Other- Certification	Expiration Date
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Other- Certification	Expiration Date
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Other- Certification	Expiration Date
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References

Name:	Relationship to applicant (e.g., supervisor, faculty, etc.)
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Name: _____ Relationship to applicant (e.g., supervisor, faculty, etc.)

Name: _____ Relationship to applicant (e.g., supervisor, faculty, etc.)

Have you ever been convicted of a felony or misdemeanor?	Yes NO	Has your nursing license ever been suspended or revoked in any state?	Yes No
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If yes, attach an explanatory note.

All information submitted to the Admissions Committee remains the property of the Truman Medical Center School of Nurse Anesthesia.

Truman Medical Center School of Nurse Anesthesia does not discriminate on the basis of race, color, national origin, gender, religion, age, marital status, physical or mental handicap or disability, sexual orientation, or any legally protected factor.

I certify that the information on this application is true, complete and accurate to the best of my knowledge. I further understand that any information given falsely or intentionally withheld will make me ineligible for admission or continued enrollment in the School. I hereby authorize UMKC School of Graduate Studies to release to Truman Medical Center School of Nurse Anesthesia, grades and evaluations.

Applicant's
Signature

Date
