

Lee College  
Student Application for Admission  
Generic A.D.N. (RN)

Type or complete in ink.

Desire DATE OF ENTRY into program: \_\_\_\_\_  
Semester Year

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Optional)

Lee College I. D. #: \_\_\_\_\_

*You are also required to turn in an application to Lee College in the Admission and Records Office. Have you turned this application in?      Yes      No*

**Name:** \_\_\_\_\_  
(Last) (First) (Middle)

**Address:** \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_ **Pager #:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**CITIZENSHIP:**

U. S. Citizen       Yes       No      Country of Citizenship: \_\_\_\_\_

**In Case of Emergency Notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_\_

**EDUCATIONAL HISTORY:**

College/Universities Attended	City/State	Dates of Attendance	Degree Awarded
-------------------------------	------------	---------------------	----------------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Have you ever attended ANY school under another name?       Yes       No

If YES, by what name(s) were you listed: \_\_\_\_\_

Have you ever enrolled in a NURSING or ALLIED HEALTH Program?       Yes       No

If YES, Name of Program/School: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

Reason of Withdrawal? \_\_\_\_\_

**CREDENTIALS:**

If you are presently licensed/certified in NURSING or an ALLIED HEALTH specialty, please answer the following:

Licensed/Certified by: \_\_\_\_\_ Date: \_\_\_\_\_

Licensure/Certificate Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ License/Certification #: \_\_\_\_\_

Has your license/certificate ever been suspended or revoked?  Yes  No

If YES, explain: \_\_\_\_\_

Date of Reinstatement: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate any Allied Health experience: \_\_\_\_\_

**GENERAL:**

Have you served in the U. S. Armed Forces?  Yes  No Dates: From: \_\_\_\_\_ to \_\_\_\_\_

Are you in the U. S. Armed Forces Reserves?  Yes  No

**LICENSURE:**

The Texas Nursing Practice Act provides a process for individuals who have reason to believe they may be ineligible for licensure to request the Board of Nurse Examiners for the State of Texas to make a determination of that issue. A frequent reason for seeking such a determination is a prior criminal conviction, a misdemeanor that involves moral turpitude, offense involving the abuse of drugs, including alcohol, or conduct resulting in the revocation of probation imposed under a conviction. Declaratory forms are available in the Allied Health Office or by contacting the Board of Nurse Examiners at (512) 305-7400.

I certify that the above statements are true and correct. It is understood that withholding or giving false information on this application will invalidate the application and/or acceptance to the program and will result in your dismissal from the program.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Revised 11/06

*If mailing application, please return the completed application to:*

*Lee College  
Allied Health Office  
P.O. Box 818  
Baytown, Texas 77522-0818*

Lee College  
Student Application for Admission  
Transitional (VN-RN)

Type or complete in ink.

Desire DATE OF ENTRY into program: \_\_\_\_\_  
Semester Year

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Optional)

Lee College I. D. #: \_\_\_\_\_

*You are also required to turn in an application to Lee College in the Admission and Records Office. Have you turned this application in?      Yes      No*

**Name:** \_\_\_\_\_  
(Last) (First) (Middle)

**Address:** \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_ **Pager #:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**CITIZENSHIP:**

U. S. Citizen       Yes       No      Country of Citizenship: \_\_\_\_\_

**In Case of Emergency Notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_\_

**EDUCATIONAL HISTORY:**

College/Universities Attended	City/State	Dates of Attendance	Degree Awarded
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Have you ever attended ANY school under another name?       Yes       No

If YES, by what name(s) were you listed: \_\_\_\_\_

Have you ever enrolled in a NURSING or ALLIED HEALTH Program?       Yes       No

If YES, Name of Program/School: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

Reason of Withdrawal? \_\_\_\_\_

**CREDENTIALS:**

If you are presently licensed/certified in NURSING or an ALLIED HEALTH specialty, please answer the following:

Licensed/Certified by: \_\_\_\_\_ Date: \_\_\_\_\_

Licensure/Certificate Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ License/Certification #: \_\_\_\_\_

Has your license/certificate ever been suspended or revoked?  Yes  No

If YES, explain: \_\_\_\_\_

Date of Reinstatement: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate any Allied Health experience: \_\_\_\_\_

**GENERAL:**

Have you served in the U. S. Armed Forces?  Yes  No Dates: From: \_\_\_\_\_ to \_\_\_\_\_

Are you in the U. S. Armed Forces Reserves?  Yes  No

**LICENSURE:**

The Texas Nursing Practice Act provides a process for individuals who have reason to believe they may be ineligible for licensure to request the Board of Nurse Examiners for the State of Texas to make a determination of that issue. A frequent reason for seeking such a determination is a prior criminal conviction, a misdemeanor that involves moral turpitude, offense involving the abuse of drugs, including alcohol, or conduct resulting in the revocation of probation imposed under a conviction. Declaratory forms are available in the Allied Health Office or by contacting the Board of Nurse Examiners at (512) 305-7400.

I certify that the above statements are true and correct. It is understood that withholding or giving false information on this application will invalidate the application and/or acceptance to the program and will result in your dismissal from the program.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Revised 11/06

*If mailing application, please return the completed application to:*

*Lee College  
Allied Health Office  
P.O. Box 818  
Baytown, Texas 77522-0818*