ARKANSAS NORTHEASTERN COLLEGE
Associate Degree Nursing Program Application for Admission

Please check which option you are applying: Traditional: _____ LPN to RN Option: _____

Date of Application: _____

Please complete and email to:
ancnursing@smail.anc.edu

or mail to:
Arkansas Northeastern College
ATTN: Nursing Department P.O. Box 1109
Blytheville, AR 72316-1109

Application Received (*Office Only*): _____

Name: _____
(Last) (First) (Middle)
(Maiden/Other)

Mailing Address:

_____
(Street Number/P.O. Box) (City) (State) (ZIP) (County)

Physical Address (if different than Mailing Address):

_____
(Street Number) (City) (State) (ZIP) (County)

Contact Phone Numbers: Primary _____ Secondary _____

Date of Birth: _____Social Security Number: _____

E-mail address: _____

Completion of this information is optional for statistical purpose and does not affect admission status.

Age: _____ Marital Status: Single _____ Married _____ Gender: Male _____ Female _____

Do you consider yourself Hispanic or Latino? Yes_____ No _____ Check all that apply:

☐ American Indian/Alaskan Native ☐ Asian/ Pacific Islander ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other (specify) _____

Have you ever been convicted of a crime? No _____ Yes _____ (If yes, include an attached explanation.)

Applying for admission in Fall _____ (provide year planning to enter ADN Program).

High School Attended:_____ Graduation Date: _____
(Name) (City) (State)

Colleges, Universities, or other schools attended (including ANC):

Institution	Dates Attended	Hours Attended	Degree (Type)	GPA
1.				
2.				
3.				

Unofficial Transcripts attached: Yes _____ No _____ Requested to be sent: Yes_____ No_____

Current Certified Nursing Assistant in AR: Yes_____ No_____ If yes, must attach copy of certification to application.

Ever held a license in any healthcare profession? Yes _____ No _____ If yes, type: _____
Ever been enrolled in any Nursing/Allied Health program at ANC? Yes _____ No _____
If yes, name of program _____ Dates attended _____

I acknowledge that all information provided is true and that misrepresenting the truth can lead to permanent dismissal from ANC's Associate Degree Nursing program. I understand that if I have been convicted of a crime, I will need permission from the Arkansas State Board of Nursing to write the NCLEX-RN.

_____ _____ _____
Print Name (legible, please) Signature Date