

Please submit this form in addition to a UFV Application for Admission.

A. PROGRAM OPTIONS

- Nursing** Preferred start date: September January
 Preferred program option: Three-year fast-track Four-year
- Practical Nursing**
- LPN Access** Preferred program option: Two-year fast-track Three-year

B. PERSONAL INFORMATION

| | | | | | | |
|--|--|------------|---|-------------------------------|--|--|
| Last name (family name) | | First name | UFV student number (if known) | | | |
| Former names (copy of birth certificate/marriage certificate/change of name will be required) | | | | | | |
| Email address | | | | Date of birth (YYYY, MMM, DD) | | |
| Phone number (with area code) | | | Alternate phone number (with area code) | | | |
| Emergency contact's name | | | Emergency contact's phone number (with area code) | | | |
| Emergency contact's address | | | | | | |
| Do you have any illness or disability to which our early attention may facilitate your participation with the program? | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify): | | | | | | |

C. APPLICATION ESSAY

All BSN, LPN Access and Practical Nursing applicants will be asked to write a one-two page essay when they attend an information session or program interview. Topics for the essay will be provided to applicants prior to the information session/program interview.

This page is to be completed by **NURSING** and **PRACTICAL NURSING** applicants only.

D. EDUCATIONAL INFORMATION

Aside from the previous high school and/or post-secondary experience you have indicated on your *UFV Application for Admission*, please list any other education you have completed (i.e., courses, seminars, conferences, etc.).

| COURSES, etc. | INSTITUTION | COMPLETION DATE |
|---------------|-------------|-----------------|
| | | |
| | | |
| | | |

E. WORK AND/OR HEALTH CARE EXPERIENCE

Work experience

| DATES | JOB/TITLE/RESPONSIBILITIES | EMPLOYER |
|-------|----------------------------|----------|
| | | |
| | | |
| | | |

Health care volunteer experience (if not employed in health care)

| DATES | JOB/TITLE/RESPONSIBILITIES | EMPLOYER |
|-------|----------------------------|----------|
| | | |
| | | |
| | | |

F. REFERENCE

See attached **Nursing/Practical Nursing** reference form, to be mailed directly to UFV by the referee.

| | |
|--|------|
| I certify that the information provided is correct. | |
| Applicant's signature | Date |

D. LPN LICENSURE

1. Do you have current CLPNBC Practicing License? Yes No

If yes, please provide your BC Licensing Number: _____

2. Are you licensed in other provinces/states/countries? Yes No

If yes, please list: _____

E. EDUCATIONAL INFORMATION

Nursing education

| YEAR(S) | INSTITUTION | LOCATION | LENGTH OF PROGRAM |
|---------|-------------|----------|-------------------|
| | | | |
| | | | |
| | | | |

F. WORK EXPERIENCE

| DATES | JOB/TITLE/RESPONSIBILITIES | EMPLOYER |
|-------|----------------------------|----------|
| | | |
| | | |
| | | |

G. REFERENCE

See attached LPN Access reference form, to be mailed directly to UFV by the referee.

| | |
|--|------|
| I certify that the information provided is correct. | |
| Applicant's signature | Date |

To the applicant: Complete this section before forwarding form to the referee.

Your name

Previous surname (if applicable)

Program (check one)

Nursing degree

Practical Nursing certificate

To be completed by the referee:

1. Please identify the applicant's **length of employment** or **number of volunteer hours**: _____
2. Briefly describe the duties the applicant performed for your institution: _____

3. Please indicate with an **X** your rating of the applicant.

| | Excellent | Average | Below Average | No basis to comment |
|------------------------|-----------|---------|---------------|---------------------|
| Attendance/punctuality | | | | |
| Safety | | | | |
| Communication | | | | |
| Working with others | | | | |
| English: Speaking | | | | |
| Writing | | | | |
| Reading comprehension | | | | |
| Creativity | | | | |
| Initiative | | | | |
| Independent thinking | | | | |

4. Please indicate your recommendation of this applicant for admission to the program indicated above and support your recommendation with comments and/or examples where appropriate.

Highly recommend Recommend Recommend with reservations Do not recommend

Comments: _____

Referee's name

Title

Institution

Phone

Address

Please return form directly by mail or fax to:

City

Postal code

School of Health Sciences
University of the Fraser Valley
45635 Yale Road
Chilliwack, BC V2P 6T4

Signature

Date

Tel: 604-795-2817 | Fax: 604-792-0733

To the applicant: Complete this section before forwarding form to the referee.

| | |
|-----------|----------------------------------|
| Your name | Previous surname (if applicable) |
|-----------|----------------------------------|

To be completed by the referee:

1. Please identify the applicant's length of employment: _____

2. Briefly describe the duties the applicant performed for your institution: _____

3. Please indicate with an **X** your rating of the applicant.

| | Excellent | Average | Below Average | No basis to comment |
|------------------------|-----------|---------|---------------|---------------------|
| Professionalism | | | | |
| Attendance/punctuality | | | | |
| Practice competence | | | | |
| Safety | | | | |
| Communication | | | | |
| Teaching ability | | | | |
| Working with others | | | | |
| English: Speaking | | | | |
| Writing | | | | |
| Reading comprehension | | | | |
| Academic potential | | | | |
| Creativity | | | | |
| Initiative | | | | |
| Independent thinking | | | | |

4. Please indicate your recommendation of this applicant for admission to the program indicated above and support your recommendation with comments and/or examples where appropriate.

Highly recommend Recommend Recommend with reservations Do not recommend

Comments: _____

| | | |
|----------------|-------------|--|
| Referee's name | | Title |
| Institution | | Phone |
| Address | | Please return form directly by mail or fax to: School of Health Sciences University of the Fraser Valley 45635 Yale Road Chilliwack, BC V2P 6T4 Tel: 604-795-2817 Fax: 604-792-0733 |
| City | Postal code | |
| Signature | Date | |