

Trinity College of Nursing & Health Sciences
Application for Admission

Complete application and return with a non-refundable \$50.00 application fee to:

Trinity College of Nursing & Health Sciences | 2122 25th Avenue | Rock Island, IL 61201-5317



Contact Us!

Trinity College of Nursing
& Health Sciences
2122 25th Ave.
Rock Island, IL 61201
(309) 779-7700
www.trinitycollegeqc.edu

Program of Study:

- | | |
|--|---|
| <input type="checkbox"/> Associate of Science in Nursing (ASN) | <input type="checkbox"/> BSN – Basic (24 months) |
| <input type="checkbox"/> LPN to ASN Advanced Placement | <input type="checkbox"/> BSN – Completion (RN-BSN) |
| <input type="checkbox"/> Bachelor of Science in Nursing (BSN) – Accelerated
(2nd degree, 15 months) | <input type="checkbox"/> Associate of Applied Science in Radiography |
| <input type="checkbox"/> BA/BSN Articulation _____
(Institution) | <input type="checkbox"/> Associate of Applied Science in Respiratory Care |
| | <input type="checkbox"/> Radiography Internship
Specialty: _____ |

Applicant Information:

Anticipated Entry Date (all programs except BSN Completion) _____
(Year)

Anticipated Entry Date for BSN Completion: Fall Spring Summer

Birth Date ____ / ____ / ____ Social Security Number ____ - ____ - ____
(Month) (Day) (Year)

Name _____
(Last) (First) (Middle) (Maiden)

Current Address _____
(Street/Box) (City) (State) (Zip Code)

Number of years/months at above address _____ E-mail Address _____

Phone: Home () _____ Work () _____ Cell () _____

This section is used for statistical information only:

Gender: Male Female

Citizenship: U.S. Other _____ If other, are you a permanent resident? Yes No
(Specify Country)

If yes, please provide copy of card. If not a permanent resident of U.S., enter your Alien registration number.
A- _____ (Trinity College of Nursing & Health Sciences does not issue an I-20.)

Ethnic Origin: Are you Hispanic or Latino? Yes No

Select one or more of the following races: American Indian or Alaskan Native Asian
 Black or African American Native Hawaiian or Other Pacific Islander White

Person to notify in case of emergency:

Name _____ Relationship _____

Address _____ Telephone Number () _____

Trinity College of Nursing & Health Sciences admits students regardless of race, color, creed, sex, national or ethnic origin, disability, or sexual orientation.



Educational Information:

List below the high school from which you graduated (only) and all colleges and universities you have ever attended.
A current, official transcript sent directly from each institution must be on file to fully process your application.
Send transcripts to: Trinity College of Nursing & Health Sciences, 2122 25th Avenue, Rock Island, IL 61201

Education	Name of Institution	City and State	Dates Attended	Diploma, Degree or Credits Earned
High School or GED (last attended)				
College				
College				
College				
College				
College				

*All previous educational institutions attended must be listed, regardless if credit was awarded or not.

Indicate college entrance examinations completed: ACT Date _____

Professional Licenses and/or Certificates:

Are you currently: Registered Licensed Certified Identify type:____ License #:_____ Exp. Date:_____

Is there a restriction on your license/certificate? Yes No If yes, explain:_____

Are you planning to apply for financial assistance? Yes No

How did you first become interested in applying to Trinity College of Nursing & Health Sciences?

- Advertising
- Family Member
- Trinity Employee
- Admissions Representative
- Friends
- Pastor
- Mailings
- High School Visit
- Faculty
- Counselor
- College Fair
- Trinity College Website
- Career Day
- Other _____

Employment:

Place of employment _____	Position _____
_____	_____
_____	_____

Read the statement below before signing:

*Please be informed that licensure or certification may be sanctioned for conviction of a crime including a **felony**, a gross misdemeanor, or misdemeanor with the exception of speeding and parking violations. Additionally, acceptance and successful completion does not guarantee licensure, certification, or employment, which may be contingent upon factors unrelated to the education process.*

Verification

I certify that the information contained in this application is accurate and complete to the best of my knowledge. I understand that any misrepresentation of the facts as stated or implied on this application is considered sufficient cause for reconsideration of my admission status, including withdrawal.

Signature _____ Date _____

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Clinical Performance Standards

To successfully perform clinical functions while enrolled at Trinity College, applicants/students must have sufficient physical strength, coordination, manual dexterity and mental and sensory processes to be capable of providing safe and effective client care. This includes but is not limited to the following situations:

- Handling stressful or demanding situations related to mechanical, technical, procedural or client care situations
- Communicating effectively in order to explain and provide client/family care
- Providing physical and emotional support to clients/families
- Physically responding to situations requiring first aid or emergency care of clients
- Using sensory skills to assess and evaluate client conditions/diagnostics tests
- Transporting, moving, lifting or transferring clients as necessary to provide care
- Moving, adjusting and manipulating a variety of equipment according to established procedures and standards
- Physically placing clients, equipment and instruments in proper positions for examinations according to established procedures and standards

If the ability to meet any of these clinical performance standards is in question, Trinity College of Nursing & Health Sciences reserves the right at any point in the application process or program of study to require a simulated clinical test to verify an applicant/student’s capabilities. If the applicant/student cannot meet these clinical performance standards without accommodation, a conference shall be held between applicant/student and the respective Program Coordinator to determine what accommodations would be necessary and if the accommodation is reasonable.

My signature indicates, that I can comply with the clinical performance standards and understand that, if with reasonable accommodation, I cannot meet these Clinical Performance Standards, I may be withdrawn at any point in the application process/program of study.

Applicant’s/Student’s Signature _____

Please Print Name _____ Date _____

Program of Study:

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- Associate of Applied Science in Radiography
- Associate of Applied Science in Respiratory Care
- Radiography Internship
Specialty: _____

Method of Payment:

Cash Check Credit Card

Credit Card Type _____ Credit Card Number _____

Name on Card _____

Billing Address _____
(Street/Box)

(City) (State) (Zip Code)

CVS Verification Code _____ Expiration Date _____

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 Rock Island, IL 61201-5317

Please make checks payable to Trinity College of Nursing & Health Sciences.