Arkansas State University
MSN Nurse Anesthesia Application Check List

You will be mailing in *two separate packets the following information:

1. Mail the following to ASU Graduate Admissions, PO Box 1570, State University, AR 72467.

- ☐ Graduate School Application (available on line at http://www.graduateschool.astate.edu)
- ☐ Payment of $30.00 for application fee
- ☐ All official transcripts
  Transcripts need to be sent from all colleges and Universities you have attended.
  Graduate level descriptive and inferential Statistics class transcript
- ☐ GRE Test Results (taken within last 5 years) a score of 300 is preferred (290 Minimum)
- ☐ Proof of MMR immunization

2. Application for Nurse Anesthesia Program. Place all of the following in an envelope and mail together.

- ☐ Completed Nurse Anesthesia Program Application (available on website)
- ☐ Personal Resume
- ☐ Professional Goal Statement
- ☐ GRE Test Results
- ☐ CCRN or CSC
- ☐ Three Recommendations, completed and sealed by person writing the recommendation (forms are available on the website)

Mail to:
ASU, School of Nursing
Nurse Anesthesia Program
PO Box 910
State University, AR 72467

You should have your current clinical supervisor, academic faculty member familiar with your academic performance, and a CRNA, Anesthesiologist, or RN fill out the Recommendation Form available on the web site and have them returned to ASU Nurse Anesthesia Program.

All of the above requirements are needed in order to be considered for an interview.

ARKANSAS STATE UNIVERSITY
MSN NURSE ANESTHESIA PROGRAM

NURSE ANESTHESIA PROGRAM APPLICATION

In addition to completing the Arkansas State University Graduate School Application, www.graduateschool@state.edu), applicants for the MSN Nurse Anesthesia Program must complete this form to be considered for admission. Please type or clearly print in black ink. **This form must be completed and returned to PO Box 910, State University, AR 72467**

1. Name ____ 2. Anticipated Enrollment Year ____________

Last First Middle

3. Phone (H) ____________________ (C) ________________ 4. E-mail address_________________________

5. Mailing Address _____________________-
____

6. School of Nursing __________________________________ Date of first RN license____________________

7. RN License:

License number	State	Expiration date

Has your RN license ever been suspended, restricted or revoked? ☐ Yes ☐ No

Have you ever been the subject of a nursing board disciplinary action? ☐ Yes ☐ No

Have you ever been denied a professional nursing license? ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

Have you ever been other than a dishonorable discharge from any branch of the US military? ☐ Yes ☐ No

If yes, Explain____

.

8. Have you ever attended another Nurse Anesthesia Program? ☐ Yes ☐ No

If yes, Explain____

.

9. Professional Certification

Type of Certification	**Issuing Agency**	**Expiration date**

Note: Students are required to have current BLS, ACLS and PALS after acceptance into the program and prior to entry and to maintain current certification throughout the program.

10. Critical Care Experience:

Name of Facility	**City and State**	**Critical Care Specialty Area List area (examples) SICU, CVICU, MICU, ICU, CCU, NICU, PICU**	From-To Month/Yr	**Full/Part time**	**Shift worked**

11. Indicate your skill level in the following categories:

	Numbers Per week	Numbers per week Independently	Numbers per week with Assistance	Number of years experience	No Experience
Arterial monitoring					
Central Venous Pressure					
Swan Ganz Catheter					
Intra-aortic Balloon Pump					
Vasoactive Drugs					
Ventilators					

12. I certify that the statements that I made on the Supplemental Application Form are accurate and complete. I understand that withholding information on this form and/or the Graduate Application Form may make me ineligible for admission to the Program or subject to dismissal after acceptance into the program.

13. I authorize the program to make inquires of my employers/educational institution

Signature of Applicant: ____________________________________ Date: ___________

Arkansas State University
Nurse Anesthesia Program

RECOMMENDATION FORM Applicant
Evaluation by Academic Faculty

Section one: To be completed by applicant.

Applicant:		
Last	**First**	**Middle**
Applying for class 20_______		

I hereby voluntarily waive and relinquish any right of access to this confidential letter of Evaluation.	**I retain my right of access to this letter of Evaluation.**
Applicant Signature Date	**Applicant Signature Date**

Section Two: To be completed by faculty of academic institution.

Instructions: A Dean or Faculty member knowledgeable about the academic performance of the applicant is asked to complete the remainder of this form.

A. Familiarity with Applicant

1. **How do you know applicant? How well do you know applicant? In what courses did you teach applicant?**

2. **How long have you known applicant?**

B. Do you believe this applicant's academic performance is indicative of his/her intellectual? ability?

☐ **Yes** ☐ **No**

C. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

D. Narrative comments:
Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

E. Overall Recommendation

Please check the box indication the category in which you would like to place this applicant.

☐ Recommend enthusiastically – upper 10 percent of applicants

☐ Recommend with confidence – upper one-third of applicants

☐ Recommend with reservation – lower one-third of applicants

☐ Do not recommend (please explain)

F. Evaluator's information:

Academic faculty Name: ____

Title: _______________

Hospital/clinical facility:____

Mailing Address: _____

City/State____________ /____________ **Zip:** _____________

Phone: ______________ **Date:** __________________

Evaluator's Signature: ____________________________ **Date:** __________________

Please return this evaluation in an official envelope directly to:

Arkansas State University,
School of Nursing,
MSN Nurse Anesthesia Program,
P.O. Box 910,
State University, AR 72467.

MSN Nurse Anesthesia Program

RECOMMENDATION FORM
Applicant Evaluation by Academic Faculty or Nursing Supervisor

Section one: To be completed by applicant.

<table>
<tr><td colspan="2">Applicant:</td></tr>
<tr><td colspan="2">Last First Middle</td></tr>
<tr><td colspan="2">Applying for class 20_______</td></tr>
<tr><td>I hereby voluntarily waive and relinquish any right of access to this confidential letter evaluation.

Applicant Signature Date</td><td>I retain my right of access to this letter of Evaluation.

Applicant Signature Date</td></tr>
</table>

Section Two: To be completed by RN, CRNA or Anesthesiologist.

Instructions: To be completed by RN, CRNA or Anesthesiologist of the applicant's choosing.

Instructions: A RN, CRNA or Anesthesiologist that possesses professional knowledge of the applicant is asked to complete the remainder of this form

A. Familiarity with Applicant

1. How do you know applicant? How well do you know applicant?

2. How long have you known applicant?

B. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

C. Narrative comments:
Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

D. Overall Recommendation
Considering all of the applicants to nurse anesthesia programs that you have known, please check the box indication the category in which you would like to place this applicant.

- ☐ **Recommend enthusiastically – upper 10 percent of applicants**
- ☐ **Recommend with confidence – upper one-third of applicants**
- ☐ **Recommend with reservation – lower one-third of applicants**
- ☐ **Do not recommend (please explain)**

E. Evaluator's information:

Nursing Supervisor's Name: ____

Title:

Hospital/clinical

Mailing

City/State_ /___________ Zip: _____________

Phone: Date: __________________

Evaluator's Signature: _____________________________ Date: ___________________

Please return this evaluation in an official envelope directly to:

Arkansas State University, Department of Nursing, MSN Nurse Anesthesia Program, P.O. Box 910, State University, AR 72467.

Arkansas State University
Nurse Anesthesia Program

RECOMMENDATION FORM Applicant
Evaluation by Nursing Supervisor

Section one: To be completed by applicant.

Applicant:		
Last	**First**	**Middle**
Applying for class 20______		

I hereby voluntarily waive and relinquish any right of access to this confidential letter of evaluation.	**I retain my right of access to this letter of Evaluation.**
Applicant Signature Date	**Applicant Signature Date**

Section Two: To be completed by current Nursing Supervisor.

Instructions: The applicant's current Nursing Supervisor is asked to complete the remainder of this form. The Nursing Supervisor's evaluation of the applicant should be based on direct observations and knowledge of the applicant.

Hospital/Medical Center where employed: ____

City____________________ State______ Employment date: Start (___/___/___) Stop (_ __/____/___)

Primary unit_________________________ #of beds________Shift worked _____Hours worked /wk. _____

Secondary unit (if any) _________________ #of beds______Shift worked ______Hours worked/wk. _____

A. Familiarity with Applicant
   1. How do you know applicant? How well do you know applicant?

   2. How long have you known applicant?

B. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					

C. Applicant Clinical Experience

Please evaluate the applicant with respect to the following clinical procedures and skills by checking the appropriate column. The admissions Committee is seeking information about the applicant regarding their critical care experience and the level of competence that they possess. If applicant was not in a critical care position at the time of employment, please skip this section (D) and write a narrative in E.

	Number Managed per week	Number Managed Independently	Number Managed with Assistance	No Experience
Arterial Monitoring				
Central Venous Pressure Monitoring				
Pulmonary Artery Pressure Monitoring				
Intra-aortic Balloon Pump				
Vasoactive Drugs				
Ventilators				
Intracranial Pressure Monitoring				
Functions as Code Blue Team Leader				
Functions as Code Blue Team Member				

E. Narrative comments:
Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.

F. Overall Recommendation
Considering all of the applicants to nurse anesthesia programs that you have known, please check the box indication the category in which you would like to place this applicant.

☐ Recommend enthusiastically – upper 10 percent of applicants

☐ Recommend with confidence – upper one-third of applicants

☐ Recommend with reservation – lower one-third of applicants

☐ Do not recommend (please explain)

G. Evaluator's information:

Nursing Supervisor's Name: ______________________________

Title: ______________

Hospital/clinical facility:______________________________

Mailing Address: _____

City/State____________ /___________ **Zip:** ____________

Phone: ______________ **Date:** ________________

Evaluator's Signature: __________________________ **Date:** ________________

Please return this evaluation in an official envelope directly to:

Arkansas State University,
School of Nursing,
MSN Nurse Anesthesia Program,
P.O. Box 910,
State University, AR 72467.

REPORT OF MEDICAL HISTORY

To the Student: Information you provide will have no effect upon your admission to University. It will be used solely as an aid in providing necessary health care while you are a student.

This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent.

SEX M☐ F☐

Last Name (Print) First Name Middle

Home Address (Number and Street) City or Town State Zip Code Date of Birth

Name, Relationship, and Address of Next of Kin Home Telephone Number

Next of Kin's Business Address Business Telephone Number

Martial Status Citizenship

S M

Class you are entering

Do you have medical insurance? Yes___ No____

Name of Company (A student insurance plan is available in Office of Student Affairs)

Immunization Completed	Yes	No	Date last injection	Have you had any of the following?			Relationship
Tetanus				Tuberculosis			
Diphtheria				Diabetes			
Small Pox				Kidney Disease			
Mumps				Heart Disease			
Rubella				Arthritis			
Polio				Stomach Disease			
Typhoid				Asthma, Hay Fever			
Other				Epilepsy, Convulsions			

PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS Comment on all positive answers in space below or on additional sheet

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Insomnia			Chest Pain/Pressure			Gallbladder Trouble		
Measles			Nervous Disorder			Diabetes			Gallstones		
German Measles			Frequent Depression			Chronic Cough			Recurrent Diarrhea		
Mumps			Seizures			Palpations (Heart)			Rupture Hernia		
Chicken Pox			Recurrent Colds			High Blood Press			Recent Gain/Loss		
Malaria			Recurrent Headaches			Lung Disease			Of Weight		
Gum or tooth Trouble			Head Injury with Unconsciousness			Rheumatic Fever Heart Murmur			Dizziness, Fainting Weakness, Paralysis		
Sinusitis			Hay Fever, Asthma			Disease or injury Of Joints			Venereal Disease Kidney Disease		
Eye Trouble			Tuberculosis			Other Injuries			Albumin/Sugar in Urine Frequent Urination		
Ears, Nose, Throat Trouble			Shortness of Breathe			Back Problems					
			Allergies			Tumor, Cancer, Cyst					
Surgery			Penicillin			Jaundice					
Appendectomy			Sulfonamides			Stomach or Intestinal Trouble					
Tonsillectomy			Serum								
Hernia Repair			Foods (which)								
Other			Other								

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reason s and durations)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous or emotional condition or personality or character disorder?		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine check-ups?)		
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons)		
G. Do you have any questions in regard to your health, family history, or other matter, which you would like to discuss now with a member of the staff of the Health Services?		

REMARKS OR ADDITIONAL INFORMATION

Comments on any items checked "Yes" above
(Use additional sheet if necessary)

Student's Signature Date

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the form below. Please comment on all positive answers. The information supplied will not be affecting the student's admission status. It will be used only as a background for providing necessary health care. This information is strictly for the use of the Health Services and will not be released without students consent. If there is a serious or chronic medical problem or you have more detailed records or recommendations, please send to the Director, Student Health Service P. O. Box 1380 Arkansas State University, State University, Arkansas 72467

SEX M F

Last Name First Name Middle

Blood Pressure______________ Height_____________inches Weight___________________Lbs.
Vision Right 20/ Left 20/ Overweight _____________________ Underweight_________________
Corrected Vision Right 20/ Left 20/ Tuberculin Skin Test Positive_____/ Negative______________-
Date of Tuberculin Skin Test ______________________________

URINALYSIS
Sugar___________
Albumin__________ Micro
____
HEMOGLOBIN (if needed) GM%
HEMATOCRIT (if needed) %
OTHER LABORATORY TESTS

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed

	Yes	No
1. Head, Ears, Nose, or Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/ Endocrine		
10. Neuropsychiatric		
11. Skin		

Is there loss or seriously impaired function of any paired organ?

Yes___ No_____

Are there any known allergies? Have you any general comments?

Recommendations for physical activity (PE, Intramurals, ROTC) Unlimited_______Limited_Explain"

Do you have any recommendations regarding the care of the student? Yes____No____

Is the patient now under treatment for any medical or emotional condition? Yes__No____

PHYSICIAN SIGNATURE____

ADDRESS (Print)____

PRINT NAME ______________________________DATE___________________