

**EMORY UNIVERSITY SCHOOL OF MEDICINE
WOUND, OSTOMY, AND CONTINENCE
NURSING EDUCATION CENTER**

APPLICATION FOR ADMISSION

Date Application Received _____

I. Personal Demographic Data

Social Security # _____

Date of Birth _____

Name: _____
Last First Middle/Maiden Professional Designations

Home Address: _____
Street Address

_____ City State Zip Code

Telephone: _____
Home Work

Fax #: _____ (H) (W) Cell: _____

E-mail: (H) _____ (W) _____

Place of Employment: _____

Current Position: _____

Name of Person to Notify in Case of Emergency: _____

Address: _____

Telephone: () _____ () _____
Home Work

Type of Program Applying for: *Onsite 10-week* _____ *Split-Option* _____ *Dist. Learn* _____

If onsite or split-option, session for which applying _____

If distance learning, state **full scope** or which *specialties* applying _____

If your **transcripts** are in a maiden or other name please note _____

C. Professional/Community Organizations to which you belong - include offices held and committee participation

D. Career Goals and Reason for applying to Emory University WOCNEC

E. Professional Liability Insurance – **ALL students must provide proof (copy of the face sheet) of Nurses Liability Coverage in the minimum amounts of 1 million per claim, and 3 million aggregate. The only exception** is if your state has legislation which regulates the amounts of coverage you may purchase. (i.e. Texas has caps on malpractice payments so the maximum amount of coverage to purchase is \$100,000 per claim, and \$300,000 aggregate). **Distance Learning and Split Option students are responsible for checking with potential clinical site(s) to find out what their requirements are. NOTE:** If you are covered by your employer’s insurance policy you must **#1) include a copy of the face sheet of the insurance policy AND #2) a simple letter, signed and dated, from your employer that you will be covered while you are here! (i.e. Jane Doe is covered while attending Emory University’s WOCNEC from (begin and end of your course dates) for both didactic and clinical in the amount of 1 million per claim, 3 million aggregate).**

Insuring Agency: _____

Address: _____

Policy #: _____ Expiration Date: _____

Limitations of Liability: _____

F. Background Check & 10 Panel Drug Screen—ALL Emory University WOCNEC students must complete a background check and 10 panel drug screen

10 WK Traditional Students –May only use Advantages Services, Inc.

6 WK Split-Option & Distance Learning Students—May use the agency of their choice but the documentation is still required!

To order at ASI visit their web site at <https://www.instant-hire.com/jobseeker/orderform.asp>; choose ‘Student Placement Package’ for \$78.50 includes both drug screen and background check. **NOTE: If you are using ASI/Infomart (www.instant-hire.com) and have questions contact:** Natalie Ellington at natalie.ellington@infomart-usa.com 770-984-2727 ext. 1376 **NOTE: ---STUDENTS MAY NOT PARTICIPATE IN ANY CLINICAL SETTINGS UNTIL REPORT IS AVAILABLE & VIEWABLE THROUGH www.insstant-ire.com!!!!!!**

(ASI/Infomart will schedule international students for drug screen after arrival in US).

IV. I hereby certify that this information is correct. I understand that any misrepresentation or omission of facts called for on this application is cause for cancellation of the application or expulsion from the program.

(Applicant's Signature) (Date)

V. I hereby give permission to include my name, address, and phone number on a list to be distributed to other students enrolled in the program, as well as to Pharmaceutical Company Representatives.

(Signature) (Date)

VI. Include a non-refundable check or money order (**US CURRENCY**) for the application fee in the amount of \$100 made payable to **Emory University WOCNEC**:

**Emory University WOCNEC
1365 Clifton Road NE, AT -732
Atlanta, GA 30322-1013**

**Please complete the following form if you would like to pay your application fee with:
VISA/MC/AMEX/DISCOVER
(Note: 3% misc. fee added to credit card orders)**

Name (as it appears on your credit card): _____
(Name)

Address that card is billed to:
(if same as applicant write "same") _____
(Billing Address)

(City, State and Zip)

Telephone: _____
(Telephone)

Card Number and Expiration Date: _____
(Credit Card Number) (Exp. Date)

(Signature) (Date) (Last 3 digits of code on back of card)

VII. How did you hear about our program?

WOCN / JWOCN _____

Another WOC (ET) Nurse _____

Industry Rep _____

Advertisement _____

Other (specify) _____