| University of California, San Francisco  **SCHOOL OF NURSING**  Application for Admission 2016-2017**POST-MASTER**’**S CERTIFICATION PROGRAM** *(NON-DEGREE)* | | |
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| **Instructions**  Submit your **complete application packet** post-marked (or hand-delivered) by **February 1, 2016** to UCSF School of Nursing, Office of Academic Programs, 525 Parnassus Avenue, Room N331B, Box 602, San Francisco, CA 94143-0602. Only complete applications—submitted with all supplemental documents—will be reviewed. A complete application **must include:**   * Completed **application form** with non-refundable $80.00 application fee (make check payable to "UC Regents") * Three (3) **letters of reference** from leaders/colleagues who can attest to your professional capabilities. Enclose each confidential reference letter in a separate sealed envelope. * One (1) official copy of your MS **transcript** to document master’s degree completion. * Copy of your **résumé/c.v./portfolio** which includes education and employment history, community service activities and volunteer or work experiences reflecting commitment to diversity and the underserved. * **Goal Statement** (except Midwifery/Women’s Health NP) Your goal statement must include the following TWO Parts:   + **Part 1:** Describe your specific goal or reason for applying to the UCSF Post Master’s Program in your designated Specialty Area. Include education/professional objectives you wish to attain upon completion of the program.   + **Part 2:** List (1) Primary Language (2) Secondary Language. If Secondary Language exits, please choose one response from the following choices in relation to (a) Clinical Setting, (b) Reading, (c) Writing, (d) Speaking.     - Able to ask and answer complete questions without assistance     - Able to ask and answer complex questions with some assistance     - Able to ask and answer simple questions     - Able to give simple directions/instructions * **MIDWIFERY/WOMEN’S HEALTH NP Applicants ONLY**:   + **Part 1**: Statement of Commitment for Practice after Completion of the Program (double-spaced and no more than 1000 words in length). The applicant should address the following:  1. Do you intend to practice full-scope nurse-midwifery after graduation in any of the following:    * 1. In rural or urban medically underserved areas: Use definitions derived from State and Federal guidelines. Applicants residing in and intending to remain in California will receive special consideration.      2. In HMO's or private practices      3. Overseas or international agencies 2. If you plan to practice selected site from a, b, or c above, demonstrate your commitment to nurse-midwifery practice by clearly and concisely addressing the following factors:    * 1. Where is the geographic area of practice anticipated by the applicant?      2. Describe the geographic area selected including total population, population needing maternity care services, health care currently available, specific needs such as expansion of Medi-Cal facilities, establishment of alternatives to existing care, facilities' history with nurse-midwifery.      3. What are the strengths and supports to nurse-midwifery practice in that area?      4. What are the barriers to practice, the weaknesses, and the problems most likely to occur?      5. Provide detailed description of physician and hospital back-up facilities currently available.      6. How does applicant plan to implement nurse-midwifery practice? If creating a new practice, how will the applicant integrate this practice into the community?  * **Part 2:** Please relate the basis for your interest in nurse-midwifery and advanced practice nursing in women’s health, and the related personal characteristics and/or aspects of your background that have brought you to consider this education program. Please include any reasons why you feel you should be given priority in selection as a student. Essay should be typewritten, double spaced, and no more than 1,000 words in length * **Part 3:** List (1) Primary Language and (2) Secondary Language. If Secondary Language exists, please choose one response from the following choices in relation to (a) Clinical Setting, (b) Reading, (c) Writing, (d) Speaking: * Able to ask and answer complex questions without assistance * Able to ask and answer complex questions with some assistance * Able to ask and answer simple questions * Able to give simple directions/instructions   In addition to the instructions above, some specialty areas may have additional prerequisites and/or required application components. Consult with the appropriate specialty area director/coordinator for further details. | | |
| **SECTION A - PERSONAL INFORMATION** | | |
| 1. Full Legal  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last         First                                           Middle    [Former Name(s)]  Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Month / Day / Year       City, State and/or Country | | |
| 2a. Permanent  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Telephone/Cell ( \_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    City        State   Zip           Country  2b. Current  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Telephone/Cell ( \_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    City        State   Zip           Country  2c. Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 3. Social Security Number \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ | | 4. Work Telephone Number ( \_\_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5a. United States 5b. Permanent  Citizen?      ☐ Yes      ☐ No Resident?      ☐ Yes      ☐ No  If **not** a U.S. citizen or Permanent Resident,      please indicate country of origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 6. Nursing License(s), e.g., RN, CNS, NP, CMN   Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Issuing State \_\_\_\_\_\_\_\_\_\_\_\_     Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Issuing State \_\_\_\_\_\_\_\_\_\_\_\_     Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Issuing State \_\_\_\_\_\_\_\_\_\_\_\_     Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 7. Health Insurance Name of   Policy?      ☐ Yes      ☐ No Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***IF YES, PLEASE ATTACH A COPY OF***  ***YOUR MEDICAL CARD*** Plan # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 8. Racial/Ethnic Background (**Optional**); please indicate:  ☐ American Indian/Alaskan Native  ☐ East Indian/Pakistani   ☐ Pilipino/Filipino ☐ Black/African-American  ☐ Japanese/Japanese-American  ☐ Pacific Islander ☐ Chicano/Mexican-American  ☐ Korean/Korean-American  ☐ Other Asian ☐ Chinese/Chinese-American  ☐ Latino/Other Spanish-American  ☐ White/Caucasian  ☐ Other, Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 9. Please indicate the Post Master's Program for which you are applying:  ☐ Adult-Gerontological Acute Care Nurse Practitioner (AG ACNP) ☐ Adult Gerontological Clinical Nurse Specialist    ☐ Advanced Practice Public Health Nursing (APPHN) ☐ Adult-Gerontology (Primary Care) Nurse Practitioner  (AGNP)  ☐ Adult-Gerontological Critical Care Trauma Clinical Nurse Specialist ☐ Family Nurse Practitioner (FNP)   ☐ Adult-Gerontological Nurse Practnr. - Occup./Environ. Health ☐ Occupational and Environmental Health Specialist  ☐ Nurse Midwifery (CNM) / Women’s Health Nurse Practitioner  ☐ Acute Care Pediatric Nurse Practitioner (ACPNP)   ☐ Health Policy  ☐ Pediatric Nurse Practitioner (PNP)   ☐ Psychiatric/Mental Health Nurse Practitioner  Name of Specialty Coordinator you’ve been in contact with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **SECTION B – LANGUAGES** | | |
| 1. Are you   bilingual?      ☐ Yes      ☐ No | 2a. Primary language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2b. Secondary language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 3. Secondary language proficiency level       In a clinical setting, are you able to ask and answer complex questions without assistance, i.e., no translator is needed?       ☐ Yes      ☐ No  READING:  ☐ Able to ask and answer complex questions without assistance  ☐ Able to ask and answer complex questions with some assistance  ☐ Able to ask and answer simple questions  ☐ Able to give simple directions/instructions  WRITING:  ☐ Able to ask and answer complex questions without assistance  ☐ Able to ask and answer complex questions with some assistance  ☐ Able to ask and answer simple questions  ☐ Able to give simple directions/instructions  SPEAKING:  ☐ Able to ask and answer complex questions without assistance  ☐ Able to ask and answer complex questions with some assistance  ☐ Able to ask and answer simple questions  ☐ Able to give simple directions/instructions | | |
| **SECTION C – CERTIFICATION** | | |
| *I certify that I have carefully considered each question and that my statements are true and complete to the best of my knowledge. Further, I understand that cancellation of my admission privileges may result if any information is found to be incomplete or inaccurate.*  Signature  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |