

**ARKANSAS NORTHEASTERN COLLEGE**  
**Associate Degree Nursing Program**  
**Application for Admission**

Please complete and mail this form to the RN Nursing Director at:

Arkansas Northeastern College

P. O. Box 1109

Blytheville, AR 72316-1109

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

Mailing Address: \_\_\_\_\_  
(Street Number) (City) (State) (Zip)

Physical Address: \_\_\_\_\_  
(Street Number) (City) (State) (Zip)

Contact Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

<b>Completion of this information is optional for statistical purposes only and does not affect admission status.</b>	
Age: _____	Marital Status: Single _____ Married _____
Sex: Male _____ Female _____	
Race: Black _____ White _____	Spanish American _____ Asian _____ Other _____

Have you ever been convicted of a Crime? \_\_\_\_\_ When you plan to enter Nursing: Fall of 20 \_\_\_\_\_

Choice of Campus (Indicate 1<sup>st</sup> and 2<sup>nd</sup> choice) Burdette \_\_\_\_\_ Paragould \_\_\_\_\_

High School Attended: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
(Name) (City) (State)

Colleges, Universities, or other Schools Attended (including ANC):

<u>Institution</u>	<u>Dates Attended</u>	<u>Hrs. Attended</u>	<u>Degree (Type)</u>	<u>GPA</u>
1. _____				
2. _____				
3. _____				
4. _____				

Ever held a license in any healthcare profession? Yes \_\_\_\_\_ Type \_\_\_\_\_ No \_\_\_\_\_

I acknowledge that all information provided is true and that misrepresenting the truth can lead to dismissal from ANC Associate Degree Nursing Program. I understand that if I have been convicted of a crime, I will need permission from the Arkansas State Board of Nursing to write the NCLEX-RN.

\_\_\_\_\_  
Print Name Student Signature (legible please) Date