

**ARKANSAS NORTHEASTERN COLLEGE**  
**Associate Degree Nursing Program**  
**Statement of Responsibility & Understanding of Functional Categories**

**Please complete and mail this form to the RN Nursing Director at:**  
**Arkansas Northeastern College**  
**P. O. Box 1109**  
**Blytheville, AR 72316-1109**

The following statements of responsibility indicate your understanding of the requirements necessary for evaluation of your file for possible admission into the ANC Associate Degree Nursing Program. Please sign and return to the Nursing Office.

I have received information from the Nursing Department at Arkansas Northeastern College concerning admission requirements for the Nursing program. I understand that it is my responsibility to ensure that all entrance criteria are met.

I accept the responsibility to validate that all copies of my transcripts and test scores are received in the Nursing Department (including those on file in other ANC offices). I will inform the Nursing Department of courses in which I am currently enrolled each semester. I also accept the responsibility to have all transcripts from other colleges submitted and evaluated by the ANC Registrar.

I understand that my Application for Admission in the Associate Degree Nursing Program will not be filed or considered unless my signature is on this form.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature (legible please)

\_\_\_\_\_  
Date

I have read and understand the Functional Ability Categories, Descriptions, and Representative Activities and Attributes.

I understand that nursing is a discipline with cognitive, sensory, affective, and psychomotor performance requirements. I understand that, if necessary and if I meet certain documentation requirements of a disability, I must contact ANC Student Services at (870) 762-1020 to request accommodations.

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Signature (legible please)

\_\_\_\_\_  
Date