

Today's Date: (mm/dd/yy)

APPLICANT'S INFORMATION (Please print or type)

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Last Name: First Name: Middle Name:
Address: Date of Birth:
(mm/dd/yy)
City: State/Province: Postal Code: Country:
Home Phone: Cell Phone: Email:
(Include country code)
Eye Color: Height Feet: Graduated High School: Primary Language:
Inches: Year:
Previous Names: (including maiden name) Mother's Maiden Name: (if any)

PROFESSIONAL EDUCATION

Name of Professional Registered Nursing School:
Address:
City: State/Province: Postal Code: Country:
Type of Nursing Program/Certificate/License:
Years: Start Date(mm/dd/yy): Graduation Date(mm/dd/yy):
Prerequisites for admission:

*B.A./B.S. Degree: Start Date: Graduation Date:
(mm/dd/yy) (mm/dd/yy)
*Master's Degree/Nursing: Start Date: Graduation Date:
(mm/dd/yy) (mm/dd/yy)

Attach a photocopy of your license that allows you to practice professional nursing in the country where you were educated

PROFESSIONAL EXPERIENCE (Attach additional sheet if necessary)

Name of Hospital/Organization:
Address: Tel. #: Fax. #:
City: State/Province: Postal Code: Country:
From: To: Position:
Supervisor's Name: Tel. #:
Supervisor's E-mail:
Describe your job duties & responsibilities: (Attach additional sheet if necessary)

Attach most recent photo here
2" by 2"
Head and shoulders only

APPLICANT'S INFORMATION (Please print or type)

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Last Name:

First Name:

Middle Name:

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you ever been licensed as a Registered Nurse in your country? Yes No

If Yes, License Type: Issue Date: (mm/dd/yy) Lic #:

Have you ever had any other health-care related license or certificate in your country? Yes No

If Yes, License Type: Issue Date: (mm/dd/yy) Lic #:

Have you ever applied for or taken an RN examination in your country? Yes No

If Yes, Please explain:

Have you ever been denied an RN or any other health-care related license/certificate in your country? Yes No

If Yes, License Type: Date: (mm/dd/yy)

Have you ever applied for or taken an RN examination in California? Yes No

If Yes, License Type: Date: (mm/dd/yy)

Have you ever been denied an RN or any other health-care related license/certificate in California? Yes No

If Yes, License Type: Date: (mm/dd/yy) Lic #:

Have you ever had disciplinary proceedings against any license as an RN or against any health-care related license, including revocation, suspension, probation, voluntary surrender, or any other proceedings in any state or country? Yes No

If Yes, please provide a detailed written explanation below, including the date and state or country where the discipline occurred:

Have you ever been convicted of any offense other than minor traffic violations? Yes No

If Yes, please provide a detailed written explanation below, including the date and state or country where the conviction occurred:

Have you ever been convicted of any drug offense? Yes No

If Yes, please provide a detailed written explanation below, including the date and state or country where the conviction occurred:

Do you take drugs which have not been prescribed for you? Yes No

If Yes, please provide a detailed written explanation below. (Please be aware that you will be tested for drug usage in the U.S.)

APPLICANT'S INFORMATION (Please print or type)

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Last Name:

First Name:

Middle Name:

Please give the score and date for any English language test you have taken:

TOEFL: Date: TOIEC: Date: MPT: Date:

IELTS: Date: TSE: Date:

ATI-RN Comprehensive Predictor: % Date: Nursing program taught in English? Yes No

Please send a copy of the official score report for every test you have taken.

WRITE BRIEFLY, IN ENGLISH, THE REASONS THAT YOU CHOSE TO BE A NURSE

I CERTIFY, UNDER THE PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT ALL INFORMATION PROVIDED IN CONNECTION WITH THIS APPLICATION IS TRUE, CORRECT AND COMPLETE. PROVIDING FALSE INFORMATION OR OMITTING REQUIRED INFORMATION IS GROUNDS FOR DENIAL

Signature of Applicant

Date

ALL INFORMATION REQUESTED ON THIS FORM MUST BE SUBMITTED WITH COMPLETE OFFICIAL TRANSCRIPTS.
 Transcripts received from the school in a foreign language will require an official English translation.
 The Original foreign language transcript and the English translation of the transcript **must both be sent.**

APPLICANT'S INFORMATION (Please print or type) **Page 4/4**

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 Address: _____ Date of Birth: _____
 (mm/dd/yy)
 City: _____ State/Province: _____ Postal Code: _____ Country: _____
 Previous Names: (including maiden name) _____ Mother's Maiden Name: (if any) _____

PROFESSIONAL EDUCATION

Name of Nursing School: _____
 Address: _____
 City: _____ State/Province: _____ Postal Code: _____ Country: _____
 Entrance Date(mm/dd/yy): _____ Graduation Date(mm/dd/yy): _____
 School Contact Name: _____ School Contact Phone: _____
 School Contact Fax: _____ School Contact Email: _____

Required Courses	Course number and /or Title	Total hours of Theory Instruction	Total hours of Lab/Clinical Instruction
Anatomy & Physiology			
Microbiology			
Medical Nursing **			
Surgical Nursing **			
Obstetric Nursing			
Pediatric Nursing			
Psychiatric Nursing			

** Attach course description(s) to this form showing evidence of **GERIATRIC** content in these nursing areas.
 Failure to submit course descriptions may delay application processing.

If you are accepted to the GLOBAL NURSING REVIEW PROGRAM, you will be required to have your educational institution submit your transcripts directly to the State of California, along with a certified English translation, if necessary.