

Name: _____ **Interview Date:** October ____, 2026 at _____

Required Document Checklist *Initial each item below to indicate submission (write **NA** if not applicable):*

_____ **Completed Application**

_____ **Current TEAS Scores** (must meet scoring criteria in Pre-entrance packet)

_____ **VBMC Employee or Cerner User Status:**

- Circle: **NO** or **YES**, Location: _____
- Cerner Username: _____
- Employee ID: _____

_____ **Valid Photo Identification** (Driver's License)

_____ **Copy of Visa / Resident Alien Card** (required for non-U.S. citizens)

_____ **Military Documents:** (if using VA benefits) DD-214, Certificate of Eligibility, and Military Transcripts

_____ **Disclosure Information** (Signed)

_____ **Confirmation of Background Check** (*check one*):

- ☐ Printed scheduled appointment ☐ Blue postcard stating "Cleared"
- ☐ Letter of Clearance from the TBON and Court Document(s)

_____ **Form Record of Previous Education and Training** (CSC – 010)

_____ **Copy of Secondary Education** (*check one*):

- ☐ Official High School Transcripts ☐ Official GED Scores ☐ Official GED Scores and High School Transcripts

_____ **Post-Secondary Transcripts**

_____ **Completed Interview Questions**

_____ **Completed Essay**

_____ **Two (2) Letters of Recommendation**

_____ **Parking Permit Form**

_____ **Form W-9**

_____ **Form Stark II**

_____ **Copy of Immunization Records**

_____ **Basic Life Support (BLS) Certification:** (*check one*):

- ☐ Copy of valid BLS Card ☐ Will attend BLS Class on **01/08/2027** (\$50.00 fee paid directly to vendor)

Applicant Acknowledgment

___ *I understand that the application and all required documents listed above are due by **October 21st by 12:00 PM.**
Missing or incomplete documents may jeopardize my acceptance into the program.*

Signature

Date

Application for Admission

Read all information and instructions before completing application.

Print all information in BLACK ink or type.

Legal Name – *Must be the exact name that appears on the Social Security Card.*

Last	First	Middle	Maiden
Social Security Number: ____ - ____ - ____		Date of Birth: ____ / ____ / ____	
Mailing Address: _____			
No. and Street		City	State Zip
Telephone: Home (____) _____		Cell (____) _____	
Email address: _____			
Emergency Contact:			
Name: _____		Relationship: _____	Phone: (____) _____

Are you a U.S. citizen? ☐ Yes ☐ No, Foreign Applicants: must submit a copy of Permanent Visa/Resident Alien card

Are you a U.S. veteran? ☐ Yes ☐ No **If using VA benefits: must submit DD-214, and Military transcripts.**

Have you ever applied/attended any Nursing Programs (RN / LVN)? ☐ **Yes**, if yes complete below. ☐ **No**

Programs: _____ Dates Attended: _____

Reason for disenrollment: _____

Are you licensed, certified, registered in any area? ☐ Yes ☐ No (this does not include Driver's licenses)

Licensed, certified, registered _____ Renewal Date: _____

Program Attended _____ State Licensure / Number _____

Employer _____ Dates of Employment ____ to ____ or currently

Address _____ Supervisor _____

Job Title _____ Job duties _____

Employer _____ Dates of Employment ____ to ____ or currently

Address _____ Supervisor _____

Job Title _____ Job duties _____

Employer _____ Dates of Employment ____ to ____ or currently

Address _____ Supervisor _____

Job Title _____ Job duties _____

Employers/Supervisors may be contacted. I, _____ give permission to release any confidential information regarding my employment.

Applicant Signature

Date

Disclosure Form and Background Check

You must read this carefully as your signature indicates you understand and accept the conditions noted below: (For further information on licensure eligibility, go to: <http://www.bon.state.tx.us/exam-eligibility.htm>, Board Rules and Regulations, 213.28 – Licensure of Persons with Criminal Convictions)

The Texas Board of Nursing (TBON) and Valley Baptist Medical Center (VBMC) are committed to providing safe care to those individuals in need of health care. Due to strict qualifications for licensure set forth by the TBON and policies on employment by Valley Baptist, you are required to submit to a Criminal Background check by assigned deadline. If the background check reveals any information, the results will be referred to Human Resources to determine eligibility for hire and possibly to the TBON for an opinion on probability for licensure.

The TBON, in compliance with the authority granted by the Texas Legislature, may refuse to approve persons to take the licensure examination who have been convicted of or received a deferred disposition for a felony, a misdemeanor involving moral turpitude, or engaged in conduct resulting in the revocation of probation.

Applicants must be able to answer "No" to the following questions in order to use the online licensure application. Other applicants may download a complete application packet. Review of applicants for licensure with eligibility issues can take three (3) to six (6) months to complete.

For any criminal offense, including those pending appeal, have you:

- A. been convicted of a misdemeanor?
- B. been convicted of a felony?
- C. pled nolo contendere, no contest, or guilty?
- D. received deferred adjudication?
- E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
- F. been sentenced to serve jail or prison time? court-ordered confinement?
- G. been granted pre-trial diversion?
- H. been arrested or have any pending criminal charges?
- I. been cited or charged with any violation of the law?
- J. been subject of a court-martial; Article 15 violation; or received any form of military judgment/punishment/action?

(You may only exclude Class C misdemeanor traffic violations.)

NOTE: Expunged and Sealed Offenses: While expunged or sealed offenses, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you submit a copy of the Court Order expunging or sealing the record in question to our office with your application. Failure to reveal an offense, arrest, ticket, or citation that is not in fact expunged or sealed, will at a minimum, subject your license to a disciplinary fine. Non-disclosure of relevant offenses raises questions related to truthfulness and character.

NOTE: Orders of Non-Disclosure: Pursuant to Tex. Gov't Code § 552.142(b), if you have criminal matters that are the subject of an order of non-disclosure you are not required to reveal those criminal matters on this form. However, a criminal matter that is the subject of an order of non-disclosure may become a character and fitness issue. Pursuant to other sections of the Gov't Code chapter 411, the Texas Nursing Board is entitled to access criminal history record information that is the subject of an order of non-disclosure. If the Board discovers a

criminal matter that is the subject of an order of non-disclosure, even if you properly did not reveal that matter, the Board may require you to provide information about that criminal matter.

- *Are you currently the target or subject of a grand jury or governmental agency investigation?*
- *Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?*
- *Within the past five (5) years have you been addicted to and/or treated for the use of alcohol or any other drug?*
- *Within the past five (5) years have you been diagnosed with, treated, or hospitalized for schizophrenia and/or psychotic disorder, bipolar disorder, paranoid personality disorder, antisocial personality disorder, or borderline personality disorder?*

I understand that as a student of the health care profession I must be able to perform a number of physical activities in the clinical portion of the program. At a minimum, I will be required to lift patients, stand for several hours at a time, and perform bending activities. If I have a chronic illness or condition I must be able to (maintain current treatment) and be able to implement direct patient care. The health care education experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. I must be able to demonstrate rational and appropriate behavior under such stressful conditions. [Individuals should give careful consideration to the mental and physical demands of the program prior to the school making the final candidate selections.]

In consideration of processing my Application for Admission, I grant permission and consent to request from any person, any and all information pertinent to my application for admission. I authorize the Valley Baptist Medical Center Vocational School of Nursing and its agents and employees to obtain and acquire any information necessary to process this application, and recognize that Valley Baptist LVN School will rely upon information it obtains. I fully release and discharge Valley Baptist LVN School and its agents and employees for their reliance on any such information obtained (including expenses, court costs, attorney fees, payment of claims and judgments), and hereby release and hold harmless from any liability or loss whatsoever.

I understand falsification of any records or documents submitted in the admission process are grounds for denial of admission to the school.

I have provided true, correct, and complete information on my application. I have read and understand the information presented in the application packet.

Signature _____ Date _____

Proof of Criminal Background Clearance Form

Student Name: _____
(Please Print)

Policy Acknowledgments

Initial next to each statement below to confirm your understanding:

- _____ **Requirement:** In accordance with the Student Handbook, every applicant must complete a Criminal Background Check (CBC) through **IdentoGO / MorphoTrust USA**
- _____ **Board Clearance:** I must receive full clearance from the **Texas Board of Nursing (BON)** to be eligible for program enrollment.
- _____ **Deadline & Non-Enrollment:** I understand that failure to submit proof of clearance from the Texas Board of Nursing on or before the first day of enrollment will result in immediate non-enrollment.

Student Signature: _____ Date: _____

Accepted Proof of Clearance

Please attach **one** of the following acceptable items to this form:

- **Scheduled Appointment Confirmation:** Proof of a scheduled fingerprinting appointment.
(Note: Students are responsible for submitting final BON clearance documentation as soon as it is received.)
- **Texas Board of Nursing Blue Postcard:** Official postcard from the Board confirming clearance.
- **Board Outcome Letter:** Official Board decision letter accompanied by any required court documents.

Record of Previous Education and Training

Texas Workforce Commission – Career Schools and Colleges Record of Previous Education and Training

Authority for Data Collection: Texas Education Code, §132.026, §132.055 and Texas Administrative Code, §807.122(e)(7), §807.191(c)

Planned Use of the Data: This form must be used by the school in its entirety to provide a record by which previous education and training may be evaluated, and credit given to the student and to provide a record of such credit and reduction of program length/cost as required by the law.

Instructions: Complete each item on front and back. If an item is not applicable, write "NA." If credit is being claimed for post-secondary education, a transcript must be provided. Credit for experience should also be granted, if justified by the school's evaluation of the student's skills. Attach additional pages as needed. The completed form is to be maintained in each student's file. A copy of the completed form will be given to the student. Credit for previous education and training cannot be granted until this form is completed and signed by the school official and the student. If clarification is required, contact Career Schools and Colleges.

School Information

School Number: S4099

School Name: Valley Baptist Medical Center School of Vocational Nursing

Student Information

Name: _____

SSN: ____ - ____ - ____

Date of Birth (mm/dd/yy): __ / __ / __

Name of Program: Vocational Nursing

Secondary Education: ☐ High School Diploma

☐ Home Schooled

☐ GED

Post-secondary Education

Type of School: ☐ College or University ☐ Technical or Vocational ☐ Other _____

Name and Location of School: _____

Dates Attended (MM/YR): From ____ / ____ To ____ / ____

Graduated: ☐ YES ☐ NO

Type of Diploma/ Degree: _____

Major Field of Study: _____

Military Education

Military Occupational Specialty and Program of study (CIP Code):

Military Experience Education or Training:

Program Hours:

Credited Hours:

Proof of Military Education provided:

Justification for not awarding military credit:

Previous Education

Identify previous experience and skills that relate to the program curriculum for which you desire credit.

FORM: CSC-010 REV1/23

Entrance Test Name and Version: ATI, TEAS Version 7Score: See attached Individual Performance Profile**School Evaluation of Previous Education and Training**

List below the subjects of this program for which credit is given, the hours of credit granted, and the justification for which the credit is granted such as skills tests, years' experience, and transcript information.

Subject: _____

Course Time * Hours of Credit: _____

Justification of Credit: _____

Credit / Price Adjustments

Original Program Length (Hrs):	Original Cost (Tuition): \$	Other \$	Total: \$
Less Credit Granted (Hrs)*:	Less Credit Granted (Tuition): (\$)	Other: \$	Total: \$
Adjusted Program Length (Hrs)*:	Adjusted Cost: \$	Other: \$	Total: \$

*Course Time * Course Time (actual hours): the total hours of time experienced by the student in the course for all types of of course time, including classroom, lab and externship hours. An hour of course time is equivalent to a 50-minute to 60-minute lecture, recitation, class (including a laboratory class or shop training) or internship, within a 60-minute period, or 60 minutes of preparation in asynchronous distance education. Intensity of course time hours vary by school and program, but typically, 100 course time hours is equivalent to about a month of full-time school.

School Official Acknowledgment

☐ I certify that all information provided by the student has been evaluated and that the student will not receive credit.

☐ I certify that all information provided by the student has been evaluated and that the student has been given credit for which he/she is entitled as identified herein.

Signature of Authorized School Official: _____

Printed Name: _____

Date (mm/dd/yy): __/__/__

Student Acknowledgment**Do not sign below unless the information above is complete and signed by the school official.**

☐ I have discussed the above evaluation of my previous education and training with the authorized school official and acknowledge that:

☐ I will receive the above stated credit, or

☐ I will not receive credit.

Printed Name of Student: _____

Signature of Student: _____

Date (mm/dd/yy): __/__/__

Individuals may receive and review information that TWC collects about the individual by emailing to open.records@twc.state.tx.us or writing to TWC Open Records, 101 E. 15th St., Rm. 266, Austin, TX 78778-0001.
FORM: CSC-010 REV1/23

NAME: _____

Date: _____

Instructions: Please provide a clear and thoughtful response to each question or scenario.

PREPAREDNESS FOR STUDENT ROLE:

1. Tell us about yourself.

Include information such as where you are from, your family, college courses completed, hobbies, community involvement, and any organizations to which you belong.

2. Do you plan on working while attending school?

☐ Yes ☐ No

If yes:

Employer/Workplace: _____

Hours per Week: _____

3. Do you have any medical or healthcare experience?

4. Do you have dependable transportation, especially for clinical rotations?

(Most clinical rotations are at Valley Baptist facilities; however, some may be off campus, including locations in Brownsville.)

☐ Yes ☐ No

If your vehicle breaks down, you have a flat tire, or experience another transportation issue, what is your backup plan?

5. Tell us about your financial plan for school.

How do you plan to pay for the nursing program?

Amount Saved (Tuition and Fees: \$12,200): (check one)

- ☐ Less than \$3,050
- ☐ \$3,050 - \$6,100
- ☐ \$6,100 - \$9,150
- ☐ More than \$9,150
- ☐ Full amount (\$12,200)

If your planned financial resources do not last throughout the year, how will you manage unexpected or emergency expenses?

6. What type of support system do you have available?

7. Why have you chosen this nursing program and or have you applied to any other nursing programs?

8. Why do you believe you would be an excellent candidate for our nursing program?

GOALS

9. What is your proudest achievement to date?

10. What has been the most challenging experience in your life so far?

11. Where do you see yourself in five years as a nurse?

NURSING

12. Why do you want to become a nurse?

13. What qualities do you believe a good nurse should possess?

14. What experiences have you had with nurses in the past?

ACADEMICS

15. Describe your study habits and how you prepare for classes and exams.

16. What would you do if you found yourself struggling in a nursing course?

17. What type of educator or supervisor do you work best with and why?

PRIORITIES

New Applicants

Nursing school requires significant preparation, including 2 to 4 hours of study most evenings, frequent testing, and early clinical start times, sometimes as early as 5:30 a.m.

18. Describe your responsibilities at home (spouse, significant other, children, household duties, caregiving, etc.) and explain how you plan to balance these responsibilities with the demands of nursing school.

19. What sacrifices do you believe you will need to make to be successful in this program?

Returning Students

20. What has changed since you were last enrolled in this program?

What factors do you believe contributed to your previous lack of success?

What will you do differently this time to ensure your success?

PERSONAL PERSPECTIVE

21. What are your personal strengths?

22. What are your personal weaknesses?

23. What would your previous supervisors, coworkers, or classmates say about you?

24. Do you consider yourself a leader, a follower, or someone who prefers to work independently?

☐ Leader ☐ Follower ☐ Independent

Why?

25. How have you handled anxiety or stressful situations in the past?

CONFLICT RESOLUTION

26. What would you do if you observed a classmate engaging in academic dishonesty, such as cheating, plagiarism, or falsifying information?

27. What would you do if you had a conflict with an instructor?

28. If you observed a nurse or nursing student doing something that could potentially harm a patient, what would you do and why?

29. You are reporting a significant change in a patient's condition to a physician, and the physician responds by yelling at you and calling you "stupid." What would you do?

30. Do you have any questions for us?

STUDENT ACKNOWLEDGMENT

By **initialing below**, I acknowledge the following:

____ I understand that planned events, including but not limited to celebrations, vacations, travel, club activities, tournaments, employment obligations, and extracurricular activities, should not interfere with my participation in the LVN Program, studies, or program requirements.

____ I understand that community service is a program requirement. Students must complete **two (2) community service activities per level**, with each activity consisting of at least **two (2) hours** of service. The program contains **three (3) levels**, requiring a minimum of **six (6) activities** during the year.

____ I understand that it is strongly recommended that students have a wireless electronic device with internet access and up-to-date software.

Applicant Signature: _____

Printed Name: _____

Date: _____

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see Purpose of Form, below.

Print or type. See Specific Instructions on page 3.	1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)	
	2 Business name/disregarded entity name, if different from above.	
	3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. ☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate ☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. ☐ Other (see instructions)	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ (Applies to accounts maintained outside the United States.)
	3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions. ☐	
5 Address (number, street, and apt. or suite no.). See instructions.		Requester's name and address (optional)
6 City, state, and ZIP code		
7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN, later.

Note: If the account is in more than one name, see the instructions for line 1. See also What Name and Number To Give the Requester for guidelines on whose number to enter.

Social security number	
OR	
Employer identification number	

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they



STARK II ACTION REQUIRED

Vendor Name: _____ Vendor Number: _____ Facility Number: _____

Dear Vendor:

In order to ensure that Tenet Healthcare Corporation ("Tenet") and its subsidiaries and affiliates, including Conifer Health Solutions, LLC ("Conifer"), and all facilities owned and operated by Tenet ("Tenet Facility") comply with federal law concerning financial arrangements between physicians and entities that provide certain health care services, we require all vendors provide us with the following information.

For purposes of answering these questions, the following definitions apply:

"Immediate family member" means the following individuals: husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

"Physician" means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry or a chiropractor.

1. Is your company owned in whole or part, directly or indirectly, by a physician who refers patients to or treats patients at any Tenet Facility or an immediate family member of a physician who refers patients to or treats patients at any Tenet Facility? ☐ NO ☐ YES
2. Is your company owned in whole or part, directly or indirectly, by any person (other than a physician or an immediate family member of a physician) who refers patients to any Tenet Facility? ☐ NO ☐ YES
3. Does your company employ or contract with a physician who refers patients to or treats patients at any Tenet Facility or an immediate family member of a physician who refers patients to or treats patients at any Tenet Facility? If "YES", please answer the following:
 - (i) Does the employed or contracted physician, or immediate family member of the physician, receive compensation from your company that is based on the volume/value of referrals to a Tenet Facility? ☐ NO ☐ YES
 - (ii) Does the compensation paid to the physician or the immediate family member of such a physician exceed fair market value for the service provided by such physician or immediate family members of such physician? ☐ NO ☐ YES
4. If you are entering into an arrangement as a vendor with Tenet, Conifer or any Tenet Facility as an individual, are you a physician who refers patients to or treats patients at any Tenet Facility or an immediate family member of a physician who refers patients to or treats patients at any Tenet Facility? ☐ NO ☐ YES

If you answered "Yes" to any of the questions (1-4) above, please indicate whether the physician/person is: ☐ an owner, ☐ an employee, or ☐ contractor of the company and complete the following:

- (a) Name of Physician or other person who refers to the Tenet facility: _____
- (b) The name(s) of any Tenet Facility to which the physician or other person refers: _____
- (c) If applicable, the name of the physician's immediate family member(s) who have ownership in the company: _____

Thank you for your anticipated cooperation in providing this information.

Sincerely,

I represent that the answers provided herein are truthful and accurate as of the date of my signature below. I agree to immediately notify _____ of any changes in the above-disclosed information.

VENDOR Officer Signature

Date

Print Name

Title

11/26/13

Vehicle Parking Registration

Student Last Name: _____ First Name: _____

Department: ____ LVN School _____

Phone Number: _____

Vehicle Information:

Primary Vehicle:

Make: _____ Model: _____ License Plate #: _____

Alternate vehicle:

Make: _____ Model: _____ License Plate #: _____

☐ Will not be driving

1. I agree to display Student parking permit in a visible area
2. I agree to park in the designated Student parking

Student Signature: _____

Office Use Only:

Parking Permit Number: _____

Parking Permit Number: _____