The University of Texas at Arlington School of Nursing
Application for Admission to Academic Partnership BSN Nursing Program

Please type or print in ink.

School of Nursing Application Due Dates:

Start Date	**Due Date**
January	June 1
June	January 5
September	March 1

THIS APPLICATION IS FOR (check one): January ___ June ___ September ___ Year _____

Partner Hospital _____

PERSONAL INFORMATION

Give full legal name. Do not use initials unless they alone constitute your complete name.

_____

Last name **First name** **Middle** **Maiden**

_____

UT Arlington Student Identification Number ***Social Security Number**

Note: The Student Identification number is used to ensure accurate matching of documents and timely processing.

_____

Date of Birth City County State Country

Current mailing address: (Note: We will mail correspondence to your current address.)

_____

Street Address Apt. # City County State Zip

Primary telephone number: _____ Cell Home Other (circle one)
Area Code Number

Secondary telephone number: _____ Cell Home Other (circle one)
Area Code Number

Primary E-mail address (required for official communication): _____
Personal UT Arlington

High School Attended _____
Name City State

Have you attended another nursing program? Yes _____ No _____

Have you taken the HESI A2? Yes _____ No _____

Send the School of Nursing application to Undergraduate Student Services, Box 19407, Arlington, TX 76019. Please apply to the University prior to submitting an application to the School of Nursing.