



PRACTICAL NURSING APPLICATION FORM

Print or type below. **Mail the completed application with the \$75.00 Application Fee (Includes the cost of testing) to: Standard Health Care P.O. BOX 9164, Reston, VA 20190.** Make money order payable to: **Standard Health Care** (no personal checks will be accepted). Application Fee is NON REFUNDABLE.

Name: _____

Address: _____

Telephone: (____) ____ - _____ Cell (____) ____ - _____

Birth Date: ____/____/19____ SSN: ____ - ____ - _____

Name of High School attended: _____

High School Diploma? _____ OR GED _____ Date awarded: _____

Do you have any college credits? _____ How many? _____

Have you had any type of training in the Health Care Field? _____ if yes, what type: _____?

_____ Where? _____

Previous Health Care Work Experience? _____ (If yes, please explain) _____

How long? _____ Where? _____

Other work Experience _____

Please indicate which *class schedule* you are registering for:

- Day Program (Monday- Thursdays; 8 AM -2 PM)
- Evening Program (Monday- Thursdays; 4-10 PM)
- Weekend Program (Fridays 4-9:30 PM, Saturdays 8 AM- 3 PM, Sundays; 2-8 PM)

