

## LPN IV THERAPY COURSE

### APPLICANT INFORMATION

(Please Print)

**Date of Application** \_\_\_\_\_

**Name** \_\_\_\_\_  
(First Name) (M.I.) (Last Name) (any other name that may appear on previous documents)

**Mailing Address** \_\_\_\_\_  
(# and Street or P. O. Box)  
 \_\_\_\_\_  
(City) (State) (Zip Code)

**E-Mail Address** \_\_\_\_\_

**Telephone Home** (\_\_\_\_) \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_ **Work** (\_\_\_\_) \_\_\_\_\_

**School of Nursing graduated from** \_\_\_\_\_ **Date of Graduation** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Ohio LPN License Number** \_\_\_\_\_

**Is your license active?** \_\_\_\_\_ **Does your license have a MEDS designation?** \_\_\_\_\_

**How did you hear about KCCC?** (select all that apply)  Web site  Newspaper  Radio  Friend/family  Flyer  
 Former student  Paper catalog  Other \_\_\_\_\_

### PHYSICAL HEALTH

**Do you have any health problems that the faculty should be aware of?** \_\_\_\_\_

**Name and telephone number of individual to be contacted in the event of an emergency:**

**Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Telephone Number** \_\_\_\_\_

### APPLICATION ACKNOWLEDGEMENT

*I agree that upon submission of this application, I will comply with all school policies when on the Knox County Career Center campus and/or school-related event.*  Yes  No

*By signing, I agree that all information on this application is true to the best of my knowledge.*

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

OFFICE USE:

Date Application Received: \_\_\_\_\_

Payment Amount Received: \_\_\_\_\_

Program Date: \_\_\_\_\_

Deposit/Payment received by: \_\_\_\_\_