



**CRUSOE-HOLIFIELD
Practical Nursing Program
Application Packet
2026-2027**

CRUSOE-HOLIFIELD PRACTICAL NURSING PROGRAM APPLICATION PACKET

PROGRAM DESCRIPTION

The Crusoe-Holifield Practical Nursing Program is designed to prepare students for successful passage of the NCLEX-PN and future employment as a Licensed Practical Nurse. Clinical experiences are included as an integral part of this program. The program is approved by the Florida State Board of Nursing.

PROGRAM OFFERINGS

Fall Semester: July – Full-time days

Spring Semester: January – Full-time days

January – Part-time evenings

PROGRAM LENGTH

The program consists of 1350 clock hours and includes 675 hours of clinical experience.

PROGRAM HOURS

Days: Classroom Monday – Thursday 8:00 a.m. – 4:00 p.m.

Clinical and Externship Hours: Vary

Evenings: Classroom: Monday - Thursday, 6:00 p.m. – 10:00 p.m.

Clinical and Externship Hours: Vary

PROGRAM LOCATION

Lively Technical College (LTC)

Health Education Department, Building 15

500 North Appleyard Drive

Tallahassee, FL 32304

(850) 487-7449

(Clinical locations vary) **Clinical rotations are included within each course for both day and evening programs (instructors will provide clinical schedules). Times and dates may vary.**

Note: Please consult another resource for more specific information like a Health Program Schedule of Start and End Dates or reach out to the Health Education Office at 850-487-7449 for details.

No person shall on the basis of sex, gender identity, marital status, sexual orientation, race, religion, ethnicity, national origin, age, color, pregnancy, disability, military status or genetic information be denied employment, receipt of services, access to or participation in school activities or programs if qualified to receive such services, or otherwise be discriminated against or placed in a hostile environment in any educational program or activity including those receiving federal financial assistance, except approved by law.” No person shall deny equal access or a fair opportunity to meet to, or discriminate against, any group officially affiliated with the Boy Scouts of America, or any other youth group listed in Title 36 of the United States Code as a patriotic society.

GENERAL REQUIREMENTS

Applicants seeking admission to the PN Program must:

- Be at least 18 years of age at projected time of program completion.
- Have a high school diploma or equivalent.
- Pass random drug screenings throughout the program. Students with positive drug screen results will be withdrawn from the program.

To apply for acceptance into the PN Program students must:

- **STEP 1 - COMPLETE THE LTC STUDENT ONLINE APPLICATION.** (This application is required for all LTC students) This application can be completed at: www.livelytech.com
- **STEP 2 - MEET WITH ADMISSIONS ADVISOR.** Admissions will review your online enrollment information. You will need to provide:
 - Two proofs of Florida Residency
 - Official Transcripts for High School and College (if applicable). For copy of your GED transcript go to www.myged.com
 - Academic Skills Test Official Results or exemption (see below for more information).
- **STEP 3 - MEET WITH FINANCIAL AID.** Financial Aid will check for all needed financial aid documents (ISIR, verification letter, etc.) Bring proof of any additional grants, scholarships, or waivers in order to receive your deferment. (If you are self-pay, you may skip this step). Federal Pell Grant information is at www.financialaid.gov. School code: 013997

COMPLETE THE PN APPLICATION PACKET

The PN Application Packet must include:

- **Health Education Student Information Sheet**
- **Writing Sample**
- **Three current reference letters:**
 - Two professional references (recent employers, former teachers, counselors, etc.)
 - One personal reference (may not be family member)

- **HESI Test Official Results (see next page for acceptable scores).** Submit with the application packet.
- **Student Health Assessment Form signed by a healthcare provider OR provide a copy of your immunization record.** Submit with the application packet.
- **Receipt of payment for a Level 2 criminal background to Leon County Schools.** This must be completed prior to submitting the application, at the student's expense*. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear background. See page 6 for details.
- **Electronic Finger Printing.** This must be completed prior to submitting the application, at the student's expense*. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear fingerprint report. See page 6 for details.
- **Vaccination Acknowledgment**

***No refunds will be issued.**

LATE OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

TESTING INFORMATION – REQUIRED TESTS & SCORE INFORMATION

Academic Skills Test

State Board Rule 6A-10.040, FAC states the following: “Students who are enrolled in a postsecondary vocational certificate program shall complete a basic skills examination.”

LTC admission policies require that all students that enroll in Workforce Education Certificate Programs of 450 hours or more must take the Academic Skills assessment test or provide proof of acceptable forms of exemption from testing.

You may be exempt from the Academic Skills test if you:

- Possess a college degree at the associate in applied science level or higher.
- Demonstrate readiness for public postsecondary education pursuant to F.S. 1008.30 (See acceptable exemptions list in Admissions).

- Earned a standard Florida public high school diploma (Student entered 9th grade in the 2003-2004 school year or any year thereafter) or earned a GED in 2014 or any year thereafter.
- Student serves as an active duty member of any branch of the United States Armed Services
- Passed a state or national industry certification or licensure examination identified in State Board of Education rules and aligned to the career education program, which they enroll.
- Proof of exemption status is required. Please see an advisor for further details in Student Services.

The academic skills test passing score for the Practical Nursing Program is an 11 in Reading, Language and Math. These scores are valid for two (2) years.

If you do not meet your exit scores, you will need to enroll in Academic (ASB) at a cost of \$31.50 per semester. The Academic Skills Building (ASB) instructor evaluates your test scores and an individualized learning plan will be designed based on your Academic Skills results. Students work individually, at their own pace, and seek the assistance of an instructor when needed.

There is a \$25.00 fee for this exam. Applicants must go to the Registration window in Building 8 to pay for the exam then report to the Testing Center.

You must be in the testing area by 9:00 am to start the Academic Skills test, Monday – Thursday or Friday by appointment only. For more information, please contact The Testing Center: 850-487-7410

HESI Admission Assessment Exam

The HESI Admission Assessment Exam is a requirement for admission into the Licensed Practical Nursing program at LTC. No other entrance exam is accepted.

The entrance exam for the Practical Nursing program includes the following:

- Math
- Reading Comprehension (including subsections)
- Vocabulary and General Knowledge
- Grammar
- Learning Styles
- Personality Style

The HESI can be taken twice in a 12-month period. The passing score on the HESI A2 entrance exam for the Practical Nursing Program is 75% or higher in

Reading Comprehension, Grammar, Vocabulary and Knowledge, English Language Composite Score, Math Score, and Cumulative Score. We will only accept one score lower than 75% in the Reading Comprehension subcategories (2-5). Scores are valid for one (1) year.

There is a \$85.00 fee for this exam. Applicants must go to the Registration window in Building 8 to pay for the exam then report to the Testing Center. Retests are \$75.00.

You must be in the testing area by 8:00 am to start the HESI test, Monday – Friday by appointment only. For more information, please contact The Testing Center: 850-487-7410

HEALTH REQUIREMENTS

Applicants are required to provide completed a Student Health Assessment Record signed by a Healthcare Provider (not more than 3 months old). If, after acceptance, a student's health status changes, further documentation may be required stating the student is physically able to continue the program. As stated on the Student Health Assessment Form, applicants are required to provide proof of the following current immunizations:

- Tetanus, within the past 10 years (Td or Tdap)
- MMR x2 (given on or after the applicant's first birthday).
- Hepatitis B series.
- Varivax x2 - History of prior illness is not acceptable.
- PPD/Tuberculin skin test within past 12 months. PPD/Tuberculin skin testing is valid for one (1) year from date of administration. Students will be required to maintain current PPD/Tuberculin skin testing throughout the duration of the program. Students who test positive for tuberculosis must show proof of a negative chest x-ray taken within the past five years to satisfy this requirement.
- COVID-19 Vaccines and Booster or Declination.
- Seasonal Flu Vaccine (August-March) or Declination.
- Additional vaccines may be required by clinical sites after enrollment.

CRIMINAL BACKGROUND CHECK/LIVESCAN FINGERPRINTING

All applicants must undergo a Level 2 criminal background through Leon County Schools. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear background. The cost for both is \$95.00. Any one who is accepted into the program with charges on their record may be withdrawn if their record prevents them from attending a clinical site.

DRUG SCREENING

Drug screening is not required prior to admission into the program. However, all students must submit to and pass three random drug screenings after entering the Practical Nursing Program and prior to having access to the clinical health care facilities utilized in the Program. This is a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement demanded of all acute care facilities in Florida. Students who do not pass a random drug screening will be withdrawn from the program.

DISABILITY SUPPORT SERVICES

If you have question regarding adult students with disabilities and accommodations, please contact LTC Student Services located in Building 9 or at 850-487-7473.

ORIENTATION

After being accepted into the LTC PN Program, applicants will be notified about attending a mandatory orientation. The date(s) and time(s) of this meeting will be given to all accepted students within their acceptance letter. For further information, please contact the Health Education Department at 850-487-7449.

FINANCIAL AID

Financial Aid is available for this program based on eligibility. Qualifying students may be awarded a Federal Pell Grant based on their current FAFSA submission provided through the Federal Student Aid, U.S Department of Education. LTC does not provide loans. Third party loans and other personal financial arrangements are a personal decision of the student and not handled at LTC. Additionally, LTC accepts other funding options (Florida Prepaid, CareerSource, VA, etc.). The Financial Aid Office is located in Building 8, phone number 850-487-7621 or 850-487-7421 and/or via email at LTCFinAid@leonschools.net. Please direct all financial aid questions directly to their office.

ACCEPTANCE INTO PROGRAM / REGISTRATION

LTC accepts applicants into the PN program only during the advertised application window. As we receive applications, potential students are scheduled for an interview with the Health Education Director or their assignee. Once the application window has closed and all applicants have been interviewed, acceptance letters will be emailed. Accepted applicants will be given an acceptance letter, which will allow them to register for the program they have applied to. Questions regarding the application process should be directed to Health Education Program at 850-487-7449.

UNIFORMS

Upon acceptance students are expected to wear the specified program uniform (Royal Blue) whenever they are in the classroom, clinical simulation or clinical facility. Uniforms may be purchased in the LTC Bookstore in Building 8. Questions regarding proper attire and uniforms should be directed to the Health Education Program at 850-487-7449.

SUCCESSFUL COMPLETION OF THIS PROGRAM DOES NOT GUARANTEE LICENSURE AS A LICENSED PRACTICAL NURSE.

The Florida Board of Nursing is responsible for protecting the public. In carrying out this responsibility, the Board of Nursing reserves the right to deny licensure to anyone who has been convicted of a crime other than minor traffic violations. Pursuant to Section 456.0635, Florida Statutes, the Florida Board of Nursing shall refuse to issue a license, certification or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted or plead guilty or nolo contendere (No Contest) to a felony violation regardless of adjudication of chapters 409, 817 or 893, Florida Statutes; or 21 U.S.C. ss. 801- 970 or 42 U.S.S. ss 1395-1396, unless the sentence and any probation or pleas ended more than 15 years prior to the application.
- Terminated for cause from Florida Medicaid Program (unless the applicant has been in good standing for the most recent five years).
- Terminated for cause by any other State Medicaid Program or the Medicare Program (unless the termination was at least 20 years prior to the date of the application and the applicant has been in good standing with the program for the most recent five years).

HEALTH EDUCATION APPLICATION COVER SHEET/CHECKLIST

Name: _____
Phone: _____ Email: _____
Program: _____ Day Night Program Date: _____

STEP 1. REGISTER FOR LIVELY TECHNICAL COLLEGE

- COMPLETE THE LTC STUDENT ONLINE APPLICATION**
Apply at www.livelytech.com
- MEET WITH STUDENT SERVICES ADVISOR**
Must bring:
 - Two proofs of Florida Residency
 - Official transcripts for High School/College/GED (For copy of GED go to www.myged.com)
- SKILLS ASSESSMENT TEST OFFICIAL RESULTS** (if needed)
- MEET WITH FINANCIAL AID**
Financial Aid is available based on eligibility.

Completed required enrollment process to LTC with Admissions. Advisor Initials: _____

STEP 2. COMPLETE THE PROGRAM APPLICATION PACKET

- HEALTH EDUCATION STUDENT INFORMATION SHEET**
- THREE CURRENT REFERENCE LETTERS:**
 - Two professional references (recent employers, former teachers, counselors, etc.)
 - One personal reference (may not be family member)
- HESITEST OFFICIAL RESULTS**
- STUDENT HEALTH ASSESSMENT FORM**
- RECEIPT OF PAYMENT FOR A LEVEL 2 CRIMINAL BACKGROUND TO LEON COUNTY SCHOOLS**
- VACCINATION ACKNOWLEDGMENT**

LATE OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

OFFICE USE ONLY:

BACKGROUND RESULTS APPROVE/ACCEPTANCE LETTER ORIENTATION



Date _____

Last Name _____ First Name _____ MI _____

Address _____ City/State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Email Address _____ Date of Birth _____

Emergency Contact _____ Phone# _____

Health Education Program applying for:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Central Sterile Processing | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Medical Assisting | <input type="checkbox"/> Nursing Assistant |
| <input type="checkbox"/> Patient Care Technician | <input type="checkbox"/> Phlebotomy | <input type="checkbox"/> Practical Nursing | <input type="checkbox"/> Professional Nursing |

EDUCATION

High School _____ City/State _____

Highest grade completed _____ Year: _____ Choose one: High School Diploma GED

Previous Nursing School _____ City/State _____

College _____ Degree Awarded _____ City/State _____

Military _____

Have you attended any previous LTC health program whether you completed or not?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Central Sterile Processing | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Medical Assisting | <input type="checkbox"/> Nursing Assistant |
| <input type="checkbox"/> Patient Care Technician | <input type="checkbox"/> Phlebotomy | <input type="checkbox"/> Practical Nursing | |

Name of Institution if other than LTC: _____

Program Attended _____ Date Attended _____

Certification Awarded Yes No Date the Certificate Awarded _____
Proof required at time of application.

EMPLOYMENT RECORD

Present _____ Title/Position _____

Dates of Employment: From _____ to _____

Previous _____ Title/Position _____

Dates of Employment: From _____ to _____

Previous _____ Title/Position _____

Dates of Employment: From _____ to _____

The information on this application is true and factual.

Signature: _____ Date: _____

THIS FORM MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER

NAME (please print): _____
Last First MI

DATE OF BIRTH: ___ / ___ / ___ Male ___ Female ___

1. MMR (Need proof of two MMR vaccines or one mumps, two measles, and one rubella. Any person born before 1/1/57 will need proof of rubella immunization or positive titer.)
 Date of MMR #1: _____ Date of MMR #2: _____
 OR
 Antibody titers:
 Mumps titer date: _____ Results: Immunity Not immune
 Rubeola titer date: _____ Results: Immunity Not immune
 Rubella titer date: _____ Results: Immunity Not immune
 If not immune, will require MMR x2.

2. Tetanus (Td or Tdap with the last ten years): Date: _____

3. Hepatitis B series:

 Hepatitis B #1 date Hepatitis B #2 date Hepatitis B #3 date
 OR
 Antibody titer date: _____ Results: Immunity Not immune

4. Varicella: **History of having Chicken Pox is not accepted.**
 Date of 1st dose: _____ Date of 2nd Dose: _____
 OR
 Varicella titer date: _____ Results: _____ (Lab value)

5. PPD (TB Skin Test): _____ Date taken: _____
 Results: _____ Positive ___ Negative ___
 Chest x-ray, if positive PPD: _____ Date: _____ Results: _____

6. Seasonal Flu Vaccine: Date of Vaccine: _____ Injection Site: _____
 (August - March) Lot Number Expiration: _____ Examiner's Initials: _____

Verified by:

 Name of Physician's Office/Health Center

 Physician's Signature

 Address of Office

 Date

PHYSICAL EXAMINATION MUST BE COMPLETED BY HEALTH CARE PROVIDER

Date of Examination MUST be within 3 months of turning in application.

	___/___/___	___/___/___
Last Name	First Name	Middle Name
Date of Birth (month/day/year)		
Examination Date		

HEIGHT _____ **WEIGHT** _____ **Vital Signs: TPR** ___/___/___ **BP** ___/___

(Specialist exams not required)

Vision: Corrected Right 20/_____
Left 20/_____
Uncorrected Right 20/_____
Left 20/_____

Color Vision _____

Hearing: (gross) Right _____
Left _____
15 ft. Right _____
Left _____

(Required tests)

Urinalysis: Sugar-_____Albumin _____
Micro _____

Hgb or Hct (if indicated) _____

Date Results _____ Recommendations _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Mouth, Throat			
2. Eyes (Include glasses: reading/continuous)			
3. Cardiovascular (Heart/Circulation evaluation)			
4. Respiratory (Airway/Chest and Lungs)			
5. PPD (If positive, chest x-ray _____ Date)			Date ___/___/___ Results (If positive, attach report)
6. Abdominal			
7. Endocrine (Include thyroid problems/diabetes, etc.)			
8. Musculoskeletal/Neurological:			
a. Sensory (other than previously noted)			
b. Motor (condition of spine/extremities?)			
11. Skin (Include latex sensitivity)			
12. Rubella/Hepatitis Screen (If no immuniz. proof)			

- A.** Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____
- B.** Is student under treatment for any medical, psychological, or emotional condition? Yes _____ No _____
Explain _____
- C.** Recommendation for physical activity. Unlimited _____ Limited _____
Explain _____
- D.** Is student physically, psychologically, and emotionally healthy? Yes _____ No _____
Explain _____

* Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in all activities. Yes _____ No _____ If no, please explain _____

X _____
Signature of Physician

Print Name of Physician

Date

State License Number





LEVEL 2 BACKGROUND SCREENING INSTRUCTIONS

Level 2 screening standards (Fingerprints) return criminal history results on arrests (including juvenile) nationwide. Under Florida Statute 1012, persons with specified access require level 2 screening. Offences outlined in Florida State Statute 435.04 (crimes of moral turpitude) can be disqualifying when persons have been found guilty of or entered a plea of nolo contendere (no contest).

Instructions:

1. Go to the Fingerprinting Office at the Leon County Schools District main office, located at **2757 W. Pensacola St., Building I** (to the right of the main district office). The hours for the Fingerprinting Office are: Monday-Friday, 8:00 am-5:00 pm - **Take this form with you.**
2. Submit payment for screening. Payment can be via credit card or money order.
3. **Obtain a receipt for the screening.**

Submit the receipt of the background screening along with the Health Education program application.

If your background screening does not come back "clear," you will be notified.

Additional information may be required.

LEVEL 2 BACKGROUND SCREENING REQUEST FORM

The following individual needs to obtain a Level 2 Background Screening, per Florida Statute 1012:

IMPORTANT:

The **ORI number for the screening is V37020031**

PLEASE PRINT

LAST NAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

DRIVER LICENSE NUMBER: _____

PHONE: _____

The above individual will be at Lively Technical College/Externship/Clinical Site for the following purpose:

___ Student

Entity/Individual from Lively Technical College making this request:
Lively Administration

Please submit print results to:

ATTENTION:

BJ Van Camp, CTE Director
Lively Technical College
500 North Appleyard Drive,
Tallahassee, Florida 32304
Fax: 850.487.7478



Electronic Fingerprinting Form

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the livescan method.
- You can find an approved Livescan Service Provider at:
<http://www.flhealthsource.gov/background-screening/> (Click on Livescan Service Providers)
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan Service Provider the Board office will not receive your background screening results.
- You must provide accurate demographic information to the Livescan Service Provider at the time your fingerprints are taken, including your Social Security number (SSN).

The Board of Nursing ORI number is - EDOH4420Z

- Typically background screening results submitted through a Livescan Service Provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ Social Security Number: _____

Aliases: _____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Race: _____
(W-White/Latino; B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ Weight: _____ Height: _____
(M=Male F=Female)

Eye Color: _____ Hair Color: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan Service provider.)

**You will need to keep this form for your records.
Do not send this form to the Board Office.**



Vaccination Acknowledgment Form

Please check the box for the program in which you are seeking admission.

- | | | |
|--|--|--|
| <input type="checkbox"/> Central Sterile Processing Technician | <input type="checkbox"/> Medical Assisting | <input type="checkbox"/> Nursing Assistant |
| <input type="checkbox"/> Patient Care Technician | <input type="checkbox"/> Phlebotomy | <input type="checkbox"/> Practical Nursing |
| <input type="checkbox"/> Professional Nursing (LPN-RN) | | |

During these times, guidance and regulations around mandatory vaccines continue to change. As a clinical requirement, some of our contracted healthcare facilities may be authorized under law to require specific vaccinations. We are committed to closely monitoring the situation in order to communicate these changes to you in a timely manner.

By signing this agreement, I hereby acknowledge that I may be required to obtain a COVID vaccine at any point in the program to be in compliance with my clinical site requirements. I acknowledge that failure to be in compliance may result in withdrawal from my program.

Student Signature

Date

Print Name

Witness Signature

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, recommends that I receive influenza vaccination to protect myself, patients, staff, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (please read and check each box):

- Influenza is a serious respiratory disease. Each year in the United States, influenza kills thousands of people and causes hundreds of thousands of hospitalizations.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect our staff and our facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before any influenza symptoms appear. During the time I shed the virus, I can transmit influenza to patients and staff in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread influenza to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- I understand that it is impossible to get influenza from influenza vaccine.
- The consequences of my refusal to be vaccinated could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers and all patients in this healthcare facility.

Despite these facts, I am choosing to decline influenza vaccination for the following reasons:

- I understand that I can change my mind at any time and accept influenza vaccination.

I have read and fully understand the information on this declination form.

Signature _____ Date _____

Name (PRINT) _____

Department _____

REFERENCE: CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, . . . Access links to current ACIP recommendations at www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html





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