



**Professional Nursing (LPN-RN) Program  
Application Packet  
2026-2027**

# CRUSOE-HOLIFIELD PROFESSIONAL NURSING (LPN-RN) PROGRAM APPLICATION PACKET

## PROGRAM DESCRIPTION

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The Professional Nursing (LPN-RN) Program is designed to prepare students for successful passage of the NCLEX- RN and future employment as a Registered 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

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2026 Fall Semester (Hybrid) : August – June

## PROGRAM LENGTH

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The program consists of 900 clock hours and includes 450 hours of clinical experience.

## PROGRAM HOURS

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Days: Tuesday, Wednesday, Thursday: 30 hours per week/10 hours per day

Clinical Hours: Vary

Externship Hours: Vary

## PROGRAM LOCATION

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Lively Technical College (LTC)  
Health Education Department, Building 15  
500 North Appleyard Drive  
Tallahassee, FL 32304  
(850) 487-7449  
(Clinical and Externship locations 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 as provided 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.*

## Professional Nursing (LPN-RN) Program FL DOE HI70608

OCP	Course Number	Course Title	Class Hours	Online Hours	Clinical Hours	Total Hours
	NSG 080	Nursing Transitions (and Program Orientation)	24	39 (-1 Clinical)	48 (+1)	111
	NSG 081	Concepts of Geriatrics and Pharmacology in Nursing	16	38	48	102
	NSG 082	Psychiatric Nursing	16	38	48	102
	NSG 083	Medical Nursing	16	38	48	102
	NSG 084	Surgical Nursing	16	38	48	102
	NSG 085	Pediatric Nursing	16	38	48	102
	NSG 086	Obstetric Nursing	16	38	48	102
	NSG 087	Professional Nursing	34	30	27	91
A	NGS 089	Senior Practicum Intensive		14 (-14 Clinical)	72 (+14)	86
Totals 1 OCP	9 Courses	Professional Nursing (LPN-RN) Courses	154 (Class hours)	311 (296 Online hours w/o clinical)	435 (450 Total clinical hours)	900 hours

**NOTE: The attendance policy is stringent. Students will only be allowed to miss a maximum of 45 hours during the entire program (year).**

## GENERAL REQUIREMENTS

Applicants seeking admission to the LPN-RN Program must:

- Be at least 18 years of age at projected time of program completion.
- Have a high school diploma or equivalent.
- Have a valid and unencumbered Florida LPN or Multistate LPN License.

To apply for acceptance into the Professional Nursing 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](http://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](http://www.myged.com)
- **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.finacialaid.gov](http://www.finacialaid.gov). School code: 013997

## COMPLETE THE LPN-RN APPLICATION PACKET

The LPN-RN Application Packet must include:

- **Health Education Student Information Sheet.**
- **Official Practical Nursing Transcript**
- **Valid and unencumbered Florida Multistate LPN License.**
- **Employment Documentation Form.** Minimum

## TESTING INFORMATION – REQUIRED TESTS & SCORE

The HESI can be taken twice in a 12-month period.

The passing score on the HESI A2 entrance exam for the LPN-RN is 75% or higher in Reading Comprehension, Grammar, Vocabulary and Knowledge, English Language Composite Score, Math Score, Anatomy and Physiology 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 an \$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 a.m. 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 a completed Student Health Assessment Record (physical must be no more than 3 months old) signed by a Healthcare Provider. 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 electronic fingerprinting is \$61.00. Anyone 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 LPN-RN 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 Admissions located in Building 9 or at 850-487-7473.

## 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 LPN-RN Program only during the advertised application window. As we receive applications, potential students are scheduled for an interview with the Health Education Coordinator 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 the Health Education Department at 850-487-7449.

## UNIFORMS

After being accepted into the LTC LPN-RN 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.

## SUCCESSFUL COMPLETION OF THIS PROGRAM DOES NOT GUARANTEE REGISTERED 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: \_\_\_\_\_ Program Date: \_\_\_\_\_

## STEP 1. REGISTER FOR LIVELY TECHNICAL COLLEGE

- COMPLETE THE LTC STUDENT ONLINE APPLICATION**  
Apply at [www.livelytech.com](http://www.livelytech.com).
- MEET WITH AN ADMISSIONS ADVISOR**  
Must bring:
  - Two proofs of Florida Residency
  - Official transcripts for High School/College/GED (For copy of GED go to [www.myged.com](http://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 Student Services. Advisor Initials: \_\_\_\_\_**

## STEP 2. COMPLETE THE PROGRAM APPLICATION PACKET

- HEALTH EDUCATION STUDENT INFORMATION SHEET**
- TRANSCRIPT FROM YOUR PRACTICAL NURSING PROGRAM(S)**
- HESITEST OFFICIAL RESULTS**
- VALID AND UNENCUMBERED FLORIDA OR MULTISTATE LPN LICENSE**
- VALID AMERICAN HEART ASSOCIATION BASIC LIFE SUPPORT CARD**
- IV THERAPY CERTIFICATION**
- EMPLOYMENT DOCUMENTATION FORM (MINIMUM OF TWO (2) YEARS EXPERIENCE (PRIVATE DUTY, AGENCY, AND HOME CARE DO **NOT** COUNT TOWARDS THE TWO YEARS))**
- THREE PROFESSIONAL REFERENCES (Form available in this application)**
- STUDENT HEALTH ASSESSMENT FORM (Must be completed by Health Provider)**
- 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 | <input type="checkbox"/> Professional 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: \_\_\_\_\_



**Accelerated LPN to RN Program  
Verification of Practice**

By my signature, I affirm that \_\_\_\_\_  
(Print full name of LPN)

is working *or*  has worked in the role of Licensed Practical Nurse.  
(check one)

Employment Dates:

Start: \_\_\_\_\_ End: \_\_\_\_\_  still employed

Facility (check one):

Medical/Surgical acute care hospital (2 years minimum) *or*  Skilled Nursing Facility  
*or*  Other

Name and type of facility: \_\_\_\_\_

Total hours worked for the last year: \_\_\_\_\_

\_\_\_\_\_  
Employer Signature from Nursing or Human Resource Department Date

\_\_\_\_\_  
Printed Name and Title

\_\_\_\_\_  
Printed Name of Agency/Facility

\_\_\_\_\_  
Contact Phone Number

*Applicants may duplicate this blank form if multiple copies are needed. Revised 03/2026.*



500 Appleyard Dr ~ Tallahassee, FL 32304 ~ 850-487-7449 ~ <https://www.livelytech.com>  
[grahamy@leonschools.net](mailto:grahamy@leonschools.net)

**Professional Nursing (LPN-RN) Reference Form**

**Applicant First Name:** \_\_\_\_\_ **Applicant Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Street Address** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

- I grant permission for disclosure of this information.
- I waive my right to see the information in this recommendation.

**Applicant Signature:** \_\_\_\_\_ **Date signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please have a current medical employer or previous instructor send the Reference Form directly to LTC at the email or address above - Attention: Professional Nursing LPN-RN Admissions. Please PRINT your responses.**

**Reference**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Contact Information-Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Facility:** \_\_\_\_\_ **How long have you known the applicant?**

\_\_\_\_\_

**Relationship to Applicant:**  Current Employer/Supervisor/Management/HR  Previous Instructor

**Please indicate with a mark on each line, where the applicant would fall between each of the following word pairs:**

←	Apathetic	Interested	→
←	Tardy	Punctual	→
←	Shy	Outgoing	→
←	Easy-going	Detail-oriented	→
←	Needs direction	Self-directed	→
←	Follower	Innovator	→
←	Status quo	Advocate	→

**Please indicate two of the applicant's star qualities and two focus areas and why:**

Star qualities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Focus areas: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please provide the following regarding the applicant's employability:**

Number of days tardy or absent in the last 90 days \_\_\_\_\_.

Number of patients cared for in a typical shift \_\_\_\_\_.

Are there any concerns about the applicant following facility policies and procedures?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Use an additional sheet for any further information.**

This information is true to the best of my knowledge.

**Reference Signature:** \_\_\_\_\_

**Date signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print Name:** \_\_\_\_\_

**Position/Title:** \_\_\_\_\_

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.**

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

**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



# 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:

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- 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](http://www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html)





## 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 1** (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



## 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                  |  |  |

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

## Essential Functions and Requirements for Professional Nursing (LPN-RN)

The following is a list of Essential Functions and Requirements for the Professional Nursing (LPN-RN) program and the clinical affiliates. Eligibility for admission will be based on the physical and mental ability to sufficiently perform the Essential Functions of the program. Reasonable accommodation will be made for each applicant; however, where reasonable accommodation does not overcome the effects of the applicant's disability or limiting conditions, a recommendation will be made to pursue an alternate program.

### Physical Requirements:

- **Visual:** Visual ability sufficient for observation and data collection necessary to provide safe client care such as: preparing and administering medications, reading fine printing/writing, and the ability to distinguish colors.
- **Auditory:** Ability sufficient to monitor and meet client needs such as: receiving verbal communication from clients and members of the healthcare team and collecting data through the use of monitoring devices such as a blood pressure monitor, stethoscope, IV infusion pumps, emergency alarms, and client call lights.
- **Gross and fine motor coordination:** To practice safe and efficient patient care such as: responding promptly and implementing skills including the manipulation of client's equipment, drawing up and giving injections to clients, performing CPR, measuring vital signs, collecting data such as peripheral pulses, client skin differences, and palpation. Able to utilize computer technology.
- **Communication:** Communication abilities sufficient for interaction with patients, family, and other healthcare members from a variety of social, emotional, cultural, and intellectual backgrounds in a coherent and concise oral and written format. Must be able to follow spontaneous verbal and/or written instructions accurately.
- **Critical thinking:** Plan and implement care in the decision-making process and exhibit adequate emotional stability to react appropriately in an emergency and in situations of high stress. Able to make decisions under pressure, have the ability to handle multiple priorities, be flexible, and interact with others in a professional manner.
- **Mobility:** Physical abilities to ambulate from room to room and department to department independently, maneuver in small spaces, navigate stairwells, re-position/lift patients in bed, and perform CPR. Reach above the head and push/pull/lift without restrictions, with the flexibility to squat and bend at the knees.

### Cognitive Requirements:

- **Assisting and Caring for Others:** Providing personal assistance, medical attention, emotional support, or other personal care to others such as coworkers, customers, or patients.
- **Documenting/Recording Information:** Entering, transcribing, recording, storing, or maintaining information in written or electronic/magnetic form.
- **Communicating with Supervisors, Peers, or Subordinates:** Providing information to supervisors, co-workers, and subordinates by telephone, in written form, e-mail, or in person.
- **Establishing and Maintaining Interpersonal Relationships:** Developing constructive and cooperative working relationships with others and maintaining them over time.
- **Getting Information:** Observing, receiving, and otherwise obtaining information from all relevant sources.
- **Making Decisions and Solving Problems:** Analyzing information and evaluating results to choose the best solution and solve problems.

- **Organizing, Planning, and Prioritizing Work:** Developing specific goals and plans to prioritize, organize, and accomplish your work.
- **Evaluating Information to Determine Compliance with Standards:** Using relevant information and individual judgment to determine whether events or processes comply with laws, regulations, or standards.
- **Updating and Using Relevant Knowledge and Best Practices:** Keeping up-to-date technically with best practices and applying new knowledge to the job role.
- **Monitor Processes, Materials, or Surroundings:** Monitoring and reviewing information from materials, events, or the environment, to detect or assess problems.

**Safety:** Basic safety standards will be introduced during the program orientation and will include the following: fire drills; active shooter drills; weather drills; bomb threats; proper use of equipment. These standards will be reinforced throughout the program.

**If any of these Essential Functions are impossible for the program applicant to perform,** it will be necessary to consider enrolling in another program. In the event that the use of special equipment compensates for non-compliance with the Essential Functions, it is the responsibility of the program applicant to purchase this equipment (e.g., electronically enhanced stethoscopes, hearing aids, or other adaptive devices, such as a magnifying glass) in order to meet the Essential Functions criteria.

**Please read this form carefully and then verify that you have been informed of these Essential Functions by signing this form. It is the applicant’s responsibility to notify FMTC of any disability prior to entering the Professional Nursing (LPN-RN) program.**

**Latex Advisory:** The use of latex based products may exist in the healthcare facilities, as well as Heath Science classrooms/labs. Individuals with latex allergies should seek expert advice from their health care provider so that they may receive information to make an informed decision regarding their exposure to latex.

I, \_\_\_\_\_, (print name) acknowledge that the above Essential Functions and Requirements does hereby serve as the notification of my expected ability to perform the requirements of the Professional Nursing (LPN-RN) Program and I attest that I have no physical limitations that would affect my meeting the requirements as listed for the LPN-RN Program.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

*The Leon County School District does not discriminate against any person on the basis of sex (including transgender status, gender nonconforming, and gender identity), marital status, sexual orientation, race, religion, ethnicity, national origin, age, color, pregnancy, disability, military status, or genetic information.*

## Next Steps After Submitting Your RN Program Application

Thank you for your interest in the RN Program. After your application is submitted, you may progress through the following stages of the selection process:

- 1. First Round – HESI Score Evaluation**

Your HESI scores will be reviewed to determine eligibility for advancement to Round Two.

*Please note:* HESI scores are highly competitive, and only the highest-scoring applicants will be selected to advance.

- 2. Second Round – LPN-RN Readiness Exam**

Applicants selected for Round Two will be required to complete the LPN-RN Readiness Exam.

Fee: \$85 (paid by the applicant).

- 3. Third Round – Skills Demonstration**

Applicants who advance to this round will participate in a practical skills demonstration.

- 4. Fourth Round – Drug Math Exam**

Applicants who progress to Round Four will be required to complete a drug calculation (“drug math”) exam.

- 5. Fifth Round – Interview**

Applicants who advance to the final round will take part in an interview.

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### Additional Information

- You will receive notification if/when you are not selected to advance to the next round.
- Acceptance letters will be sent via email.



**850-487-7555**  
**[www.livelytech.com](http://www.livelytech.com)**

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