

Application for Admission 2019-2020
POST-MASTER'S CERTIFICATION PROGRAM (NON-DEGREE)

Instructions

Submit your **complete application packet** post-marked (or hand-delivered) by **Monday, February 4, 2019** to UCSF School of Nursing, Office of Academic Programs, 2 Koret Way, Room N331B, Box 602, San Francisco, CA 94143-0602. Only complete applications—submitted with all supplemental documents—will be reviewed. A complete application **must include:**

- Completed **application form** with non-refundable \$90.00 application fee (make check payable to "UC Regents")
- Three (3) **letters of reference** from leaders/colleagues who can attest to your professional capabilities.
Enclose each confidential reference letter in a separate sealed envelope.
- One (1) official copy of your **MS transcript** to document master's degree completion.
- Copy of your **résumé/c.v./portfolio** which includes education and employment history, community service activities and volunteer or work experiences reflecting commitment to diversity and the underserved.
- **Goal Statement** (except Midwifery/Women's Health NP) Your goal statement must include the following **TWO** Parts:
 - **Part 1:** Describe your specific goal or reason for applying to the UCSF Post Master's Program in your designated Specialty Area. Include education/professional objectives you wish to attain upon completion of the program.
 - **Part 2:** List (1) Primary Language (2) Secondary Language. If Secondary Language exists, please choose one response from the following choices in relation to (a) Clinical Setting, (b) Reading, (c) Writing, (d) Speaking.
 - Able to ask and answer complete questions without assistance
 - Able to ask and answer complex questions with some assistance
 - Able to ask and answer simple questions
 - Able to give simple directions/instructions
- **MIDWIFERY/WOMEN'S HEALTH NP Applicants ONLY:**
 - **Part 1:** Statement of Commitment for Practice after Completion of the Program (double-spaced and no more than 1000 words in length). The applicant should address the following:
 - 1) Do you intend to practice full-scope nurse-midwifery after graduation in any of the following:
 - a) In rural or urban medically underserved areas: Use definitions derived from State and Federal guidelines. Applicants residing in and intending to remain in California will receive special consideration.
 - b) In HMO's or private practices
 - c) Overseas or international agencies
 - 2) If you plan to practice selected site from a, b, or c above, demonstrate your commitment to nurse-midwifery practice by clearly and concisely addressing the following factors:
 - a) Where is the geographic area of practice anticipated by the applicant?
 - b) Describe the geographic area selected including total population, population needing maternity care services, health care currently available, specific needs such as expansion of Medi-Cal facilities, establishment of alternatives to existing care, facilities' history with nurse-midwifery.
 - c) What are the strengths and supports to nurse-midwifery practice in that area?
 - d) What are the barriers to practice, the weaknesses, and the problems most likely to occur?
 - e) Provide detailed description of physician and hospital back-up facilities currently available.
 - f) How does applicant plan to implement nurse-midwifery practice? If creating a new practice, how will the applicant integrate this practice into the community?
 - **Part 2:** Please relate the basis for your interest in nurse-midwifery and advanced practice nursing in women's health, and the related personal characteristics and/or aspects of your background that have brought you to consider this education program. Please include any reasons why you feel you should be given priority in selection as a student. Essay should be typewritten, double spaced, and no more than 1,000 words in length
 - **Part 3:** List (1) Primary Language and (2) Secondary Language. If Secondary Language exists, please choose one response from the following choices in relation to (a) Clinical Setting, (b) Reading, (c) Writing, (d) Speaking:
 - Able to ask and answer complex questions without assistance
 - Able to ask and answer complex questions with some assistance
 - Able to ask and answer simple questions
 - Able to give simple directions/instructions

In addition to the instructions above, some specialty areas may have additional prerequisites and/or required application components. Consult with the appropriate specialty area director/coordinator for further details.

SECTION A - PERSONAL INFORMATION

1. Full Legal Name _____
Last _____ First _____ Middle _____ [Former Name(s)] _____
Date of Birth _____ Place of Birth _____
Month / Day / Year City, State and/or Country

2a. Permanent Address _____ Telephone/Cell (_____) _____
City _____ State _____ Zip _____ Country _____

2b. Current Address _____ Telephone/Cell (_____) _____
City _____ State _____ Zip _____ Country _____

2c. Email _____ Alternate Email _____

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3. Social Security Number _____ 4. Work Telephone Number (_____) _____

5a. United States Citizen? Yes No
5b. Permanent Resident? Yes No
If not a U.S. citizen or Permanent Resident, please indicate country of origin _____

6. Nursing License(s), e.g., RN, CNS, NP, CMN
Type _____ License Number _____ Issuing State _____ Exp. Date _____
Type _____ License Number _____ Issuing State _____ Exp. Date _____
Type _____ License Number _____ Issuing State _____ Exp. Date _____

7. Health Insurance Policy? Yes No Name of Insurance Company _____
IF YES, PLEASE ATTACH A COPY OF YOUR MEDICAL CARD Plan # _____ Policy # _____

8. Racial/Ethnic Background (Optional); please indicate:
 American Indian/Alaskan Native East Indian/Pakistani Pilipino/Filipino Black/African-American
 Japanese/Japanese-American Pacific Islander Chicano/Mexican-American Korean/Korean-American
 Other Asian Chinese/Chinese-American Latino/Other Spanish-American White/Caucasian
 Other, Please Specify: _____

9. Please indicate the Post Master's Program for which you are applying:

<input type="checkbox"/> Acute Care Pediatric Nurse Practitioner (ACPNP)	<input type="checkbox"/> Adult Gerontological Clinical Nurse Specialist (AG CNS)
<input type="checkbox"/> Adult-Gerontological Acute Care Nurse Practitioner (AG ACNP)	<input type="checkbox"/> Adult-Gerontology (Primary Care) Nurse Practitioner(AGPCNP)
<input type="checkbox"/> Adult-Gerontological Primary Care Nurse Practitioner - Occupational/Environmental Health (AGPCNP-OEH)	<input type="checkbox"/> Advanced Public Health Nursing (APHN)
<input type="checkbox"/> Certified Nurse Midwife/Women's Health Nurse Practitioner (CNM/WHNP)	<input type="checkbox"/> Family Nurse Practitioner (FNP)
<input type="checkbox"/> Health Policy	<input type="checkbox"/> Neonatal Clinical Nurse Specialist (NEO-CNS)
<input type="checkbox"/> Neonatal Nurse Practitioner (NNP)	<input type="checkbox"/> Pediatric Nurse Practitioner (PNP)
<input type="checkbox"/> Psychiatric/Mental Health Nurse Practitioner	

Name of Specialty Coordinator you've been in contact with _____

SECTION B - LANGUAGES

1. Are you bilingual? Yes No
2a. Primary language _____
2b. Secondary language _____

3. Secondary language proficiency level
In a clinical setting, are you able to ask and answer complex questions without assistance, i.e., no translator is needed?
 Yes No

READING:
 Able to ask and answer complex questions without assistance
 Able to ask and answer complex questions with some assistance
 Able to ask and answer simple questions
 Able to give simple directions/instructions

WRITING:
 Able to ask and answer complex questions without assistance
 Able to ask and answer complex questions with some assistance
 Able to ask and answer simple questions
 Able to give simple directions/instructions

SPEAKING:
 Able to ask and answer complex questions without assistance
 Able to ask and answer complex questions with some assistance
 Able to ask and answer simple questions
 Able to give simple directions/instructions

SECTION C - CERTIFICATION

I certify that I have carefully considered each question and that my statements are true and complete to the best of my knowledge. Further, I understand that cancellation of my admission privileges may result if any information is found to be incomplete or inaccurate.

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Signature _____ Date _____

Print Name _____