Vocational Nursing Program

APPLICATION PACKET MUST BE TURNED IN BY May 1, 2024 no later than 12:00 P.M. (Noon)

Application Period is October 18, 2023 to May 1, 2024

**** NO LATE APPLICATIONS WILL BE ACCEPTED ****

APPLICATION PACKET MAY BE BROUGHT INTO THE OFFICE ANYTIME BEFORE THE DEADLINE

Application Packet Turn In Location:

SPC Plainview Center
1920 W. 24th St.
Nursing Office PC104A
Plainview, TX 79072

<u>The Application Packet Documents</u>

VNSG application for admission
Criminal Background Certification
Information Regarding Course Work
English Proficiency of Student Nurse
Verification of Workplace Eligibility
High School Transcript / GED Scores showing a 2.0 or higher GPA
TSI Compliance
TEAS Scores for Reading, Math, English (Each score of 58.7 or higher), Science (points awarded based on score)
Official Transcripts from all colleges and/or universities attended outside of SPC (Cumulative GPA 2.0 or Higher)
Physical Form completed by physician

Immunizations:

- current TB test
- Tdap
- MMR [2 doses]
- Hepatitis B [3 doses],
- Varicella [2 doses]
- Flu shot will be required by Oct., 1, 2024
- Copy of Covid vaccine or Declination form

American Heart Association CPR Certification

CPR for Health Care Provider by the American Heart Association [Suggested CPR Sources: Covenant Health Plainview-Kristin Rodriguez (806) 777-2579 OR First Response Resources – (806) 791-2582.] Be sure that you get the correct CPR—we cannot accept other types!

SOUTH PLAINS COLLEGE
VOCATIONAL NURSING
PROGRAM APPLICATION
FOR ADMISSION

PLEASE PRINT IN INK OR TYPE: **Select the Campus to Attend**: Levelland ☐ Reese ☐ Plainview ☐ DATE: ___________________

NO APPLICATIONS WILL BE TAKEN WITHOUT SPC COLLEGE ID NUMBER - LOOK ON CAMPUS CONNECT FOR INFORMATION

STUDENT COLLEGE ID#: ________________________________ SEMESTER APPLYING FOR: ____________________

NAME: ____
Last First Middle Former or Maiden Name

ADDRESS: __________________________ ____
City State Zip Code

TELEPHONE: ________________________ DOB ____________________SOCIAL SECURITY_______________________

(ALL CORRESPONDENCE WILL BE THROUGH E-MAIL ONLY)

WORKING E-MAIL ADDRESS: ____

Are you a military veteran? ☐ yes ☐ no High School ☐ or GED ☐ or Home School ☐

High School Name: ____

College: ______________________________________ Degree: ___________________________________

______________________________________ ___________________________________

Any Health-Care Training: ☐ YES ☐ NO TYPE: _____________ Facility: ____________________________

Certifications: ____

Employment in healthcare setting ☐ YES ☐ NO Dates worked within last 5 years ___________________________

Have you previously attended a nursing program? LVN ☐ DIPLOMA ☐ ADN ☐ BSN ☐

Date Attended _________________

Name and Address of Nursing School attended ____

Reason for withdrawal: ____

Are you eligible for Re-Admission YES ☐ NO ☐

(If yes, must provide a Letter of Standing from previous School of Nursing.)

Have you ever repeated any science courses? YES ☐ NO ☐

If YES, list the reason why____

Provide a short essay on why you have chosen nursing as a career and list some of your career goals using the space provided here.

IN CASE OF AN EMERGENCY, PLEASE NOTIFY (LIST TWO [2] PERSONS WITH PHONE NUMBERS):

____

____

____

I hereby certify that the above information is true and correct and I realize that giving false information or willfully withholding pertinent information will result in disciplinary actions including dismissal from the program. I hereby authorize South Plains College to verify any of the information on this application. I also understand that this completed application and other required information must be submitted to the program director to be considered for admission to this program.

I certify the statements made on this application are true.

APPLICANT'S SIGNATURE: ______________________________ DATE: ________________

It is the policy of South Plains College to offer all educational and employment opportunities without regard to race, color, national origin, sex, handicap or age.

NOTE: Falsification of any information or omission of information on this application will result in denial of admission into the program. If a student is admitted to the program and it is later determined that information was falsified or omitted, the student will be dismissed from the program.

Criminal Background Certification

The following are the questions that each candidate for licensure must answer. You may access the full information from the BON's website at www.bon.state.tx.us

1. Are you enrolled, planning to enroll, or have you graduated from a nursing program?

Name of Nursing Program: ____
Location: ____
City______________________State______________________

Type of Nursing Program: (check one) LVN ☐ ADN ☐ Diploma ☐ BSN ☐

Date of Enrollment: ________________ Date of Graduation: ____________________

2. **Write Yes or No for any criminal offense, including those pending appeal: (Please answer in each space provided)**

______A. been convicted of a misdemeanor?
______B. been convicted of a felony?
______C. pled nolo contendere, no contest, or guilty?
______D. received deferred adjudication.
______E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
______F. been sentenced to serve jail or prison time? Court-ordered confinement?
______G. been granted pre-trial diversion.
______H. been arrested or have any pending criminal charges?
______I. been cited or charged with any violation of the law?
______J. been subject of a court-martial; Article 15 violation; or received any form of military judgment/punishment/action?

You may only exclude Class C misdemeanor traffic violations. You will need a declaratory order for arrests while a minor.

NOTE: Expunged and Sealed Offenses:

While expunged or sealed offenses, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you submit a copy of the Court Order expunging or sealing the record in question to our office with your application. Failure to reveal an offense, arrest, ticket, or citation that is not in fact expunged or sealed, will at a minimum, subject your license to a disciplinary fine. Non-disclosure of relevant offenses raises questions related to truthfulness and character.

NOTE: Orders of Non-Disclosure:

Pursuant to Tex. Gov't Code § 552.142(b), if you have criminal matters that are the subject of an order of non-disclosure you are not required to reveal those criminal matters on this form. However, a criminal matter that is the subject of an order of non-disclosure may become a character and fitness issue. Pursuant to other sections of the Gov't Code chapter 411, the Texas Nursing Board is entitled to access criminal history record information that is the subject of an order of non-disclosure. If the Board discovers a criminal matter that is the subject of an order of non-disclosure, even if you properly did not reveal that matter, the Board may require you to provide information about any conduct that raises issues of character.

(OVER)

3. [ ] **Yes** [ ] **No** Are you currently the target or subject of a grand jury or governmental agency investigation?

4. [ ] **Yes** [ ] **No** Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?

5. [ ] **Yes** [ ] **No** *Within the past five (5) years have you been addicted to and/or treated for the use of alcohol or any other drug?

6. [ ] **Yes** [ ] **No** *Within the past five (5) years have you been diagnosed with, treated, or hospitalized for schizophrenia and/or psychotic disorders, bipolar disorder, paranoid personality disorder, antisocial personality disorder, or borderline personality disorder?*****

If "**YES**" indicate the condition: [ ] schizophrenia and/or psychotic disorders, [ ] bipolar disorder, [ ] paranoid personality disorder, [ ] antisocial personality disorder, [ ] borderline personality disorder *Pursuant to Occupations Code §301.207, information regarding a person's diagnosis or treatment for a physical condition, mental condition, or chemical dependency is confidential to the same extent that information collected as part of an investigation is confidential under the Occupations Code §301.466. You may indicate "NO" if you have completed and/ or are in compliance with Texas Peer Assistance Program for Nurses (TPAPN) for substance abuse or mental illness.

***IF YOU ANSWER "YES" TO ANY QUESTION #2 - #6, YOU MUST PROVIDE A SIGNED AND DATED LETTER TO THE BOARD OF NURSING DESCRIBING THE INCIDENCE(S) THAT YOU ARE REPORTING TO THE BOARD, AS WELL AS SUPPORTING DOCUMENTATION. REFER TO THE INSTRUCTIONS PAGE FOR MORE INFORMATION.
https://www.bon.texas.gov/forms_declaratory_order.asp.html

Attestation

I, the Petitioner referenced in this application, acknowledge this document is a legal document and I attest that the statements herein contained are true in every respect. I understand that no one else may submit this form on my behalf and that I am accountable and responsible for the accuracy of any answer or statement on this form. Further, I understand that it is a violation of the 22 TAC § 217.12 (6)(I) and the Penal Code, sec 37.10, to submit a false statement to a government agency; and I consent to release of confidential information to the Texas Board of Nursing and further authorize the Board to use and to release said information
as needed for the evaluation and disposition of my application.

I understand that if I have any questions regarding this affidavit I should contact an attorney or the appropriate professional health provider.

I will immediately notify the Board if at any time after signing this affidavit I no longer meet the eligibility requirements.

APPLICANT'S SIGNATURE: ______________________________ DATE: ________________

APPLICANT'S NAME (PRINT): ____________________________ DATE: ________________

SOCIAL SECURITY # ______________________________

SOUTH PLAINS COLLEGE
VOCATIONAL NURSING
PROGRAM
INFORMATION REGARDING COURSE WORK

Student Name:_________________________________

TSI Compliant: Y☐ N ☐

TEAS Status: Reading, English, and Math 58.7 or higher and Science (points awarded based on score): Y☐ N☐

Cumulative GPA 2.0 or higher _____

Complete the American Heart Association Certified CPR Class prior to applying for Vocational Nursing Program.

** Anatomy and Physiology I & II must both be completed within the last 5 years with a score of A or B in order to be considered as an exemption for VNSG 1420 A&P for Allied Health. No more than 2 sciences total may be repeated.**

I authorize my grades to be released to the SPC Vocational Nursing Program Director.

APPLICANT'S SIGNATURE: _________________________________ DATE: __________________

English Proficiency of Student Nurses

Communication with patients, families, staff, instructors, and other personnel is an important, therapeutic nursing skill that all nurses must possess. Communication includes understanding the message and being understood. All student nurses must be proficient in oral English skills. Please sign this form and mark the appropriate statement which best describes your oral English proficiency.

Print Name: ____

Student ID: ____

☐ (1) I possess the oral English skills necessary for effective communication with patients, families, staff, instructors, and other health care personnel.

☐ (2) I do not possess the oral English skills necessary for effective communication with patients, families, staff, instructors, and other health care personnel.

APPLICANT'S SIGNATURE: ______________________________ DATE: ______________

Verification of Workplace Eligibility

It is the policy of UMC/Covenant that any former employee who is ineligible for rehire **CANNOT** perform clinical rotations at UMC/Covenant until approved by agency administration.

****Turn in written approval before admitted into the program****

If a student is unable to perform clinical rotations at UMC/Covenant, they are ineligible to enter South Plains College Nursing Programs.

Print Name: ____

Check one of the following:

☐ I have never been employed by the major hospitals here in Lubbock.

☐ I am currently employed at ___________________________________

☐ I have been employed in the past at ____________________________ and I am

a) ☐ Eligible for re-hire

b) ☐ Not eligible for re-hire

APPLICANT'S SIGNATURE: ______________________________ DATE: ________________

South Plains College
Vocational Nursing Program - Plainview Center
IMMUNIZATION REQUIREMENTS AND PHYSICAL FORM

NAME______________________________________ADDRESS ____
(City, State, Zip)

PHONE NUMBER________________________________Student ID #____

AGE______________SEX______________DATE OF BIRTH________________________WT.______________Ht.__________ ____________

Health Care Provider____________________________DATE OF VISIT____

Please have your physician or health clinic complete the following data. Our program follows the requirements of the area hospitals where student clinical rotation is completed. **Please bring a printed list of all current medication(s) prescribed by your physician**

I. IMMUNIZATIONS:

A. MMR VACCINE: If you were born after 1957, you must show proof of two vaccines, or lab titer, by physician's dated statement and immunization record. If your lab titer or vaccine was before 1980-, you must have it repeated because of a major change in the vaccine that year.

Date: ___________ Date: ______________ Titer Level: _______________ Immune: Yes □ No □

B. VARICELLA: must have either vaccine or titer showing immunity

Titer: Date: ___________________ Immune: Yes □ No □
Vaccine: Date: _________________ Date: ___________________

C. HEPATITIS B in a series of 3 doses is required. Serologic testing for response to the series (titer) must be completed 1-2 months after receiving the last dose of vaccine. If the titer is positive, no further testing is required for life. If the titer is negative, the 3 dose series must be repeated with a titer 1-2 months after the last dose. If the second titer is negative, counseling will be initiated regarding non-responder status. **If you have not had a titer drawn and received the series as an infant, you must get a booster followed by a titer one month later.**

Date: ________ Date: ________ Date: ________ Titer Date: ________ Titer Level: ___________ Immune: Yes □ No □
Date: ________ Date: ________ Date: ________ Titer Date: _________ Titer Level: ___________ Immune: Yes □ No □

D. TDAP Vaccine (Must be within last 10 years) Date: _________________

E. Meningococcal Vaccine (MCV4): Required if under 22 years of age Date: _________________

F. TB Test (MANTOUX PPD) must be within last 12 months:
Date: _____________________________ Results: ______________________________

IF POSITIVE: X-RAY Date: __________ Results: _________________ Treatment: _____________________

(Additional x-rays every two years are no longer required. Refer for follow-up & treatment if becomes Symptomatic).

G. Flu Vaccine: ___________________ (August candidates must have new flu vaccine each October)

H. COVID-19 Vaccine: #1__________________ #2 ________________ OR J&J________________________

Please provide a COPY of all vaccinations in addition to the documentation above. Declination forms available per request if declining to receive flu vaccine or COVID vaccine.

II. EXAM DATA

Blood pressure____________________________________ Pulse ________ Respirations: ____________________

Range of Motion: _____________________Bending_______________________ Squats ____

General Physical Condition:____

____

In your opinion, is this individual in suitable physical and emotional condition to attend the Vocational Nursing Program?

____

If not, why? ____

______________________________________ ______________________________________

Signature of Examining Health Care Provider — Health Care Provider's Name (please print)

III. PHYSICAL HISTORY: (to be completed by applicant)

A. Communicable Disease History: Circle answer

Have you had?	Have you received:	Sexually transmitted diseases
Chickenpox .... yes no	Rubella vaccine ....yes no	Syphilis ....yes no
Measles/Rubeola........... yes no	Measles vaccine ....yes no	Gonorrhea ....yes no
Rubella .... yes no	Polio vaccine ....yes no	Other ....yes no
Scarlet Fever .... yes no	Mumps vaccine ....yes no	If yes, when and how treated
Hepatitis .... yes no	Hepatitis B vaccine ....yes no	___________________________
What type? ________________	When ________________________	
COVID-19................yes no	COVID-19 vaccine........yes no	

Tuberculosis (TB) History:

Have you lived outside the United States? Where? ____ yes no

Family member ever have TB or been treated for TB? .... yes no

Have you ever been treated for TB? .... yes no

Have you ever had a POSITIVE TB skin test? .... yes no

If yes, last chest x-ray?

Have you ever had the BCG vaccine:.. yes no

B. Accidents/Illness On-The-Job:

Have you ever had an accident, injury, or illness, which caused you to lose time from work?

If yes, give date and explain. ____ yes no

Have you received or been receiving COMPENSATION as a result of injury or illness? .... yes no

Did you receive a settlement for the injury or illness? .... yes no

Do you have any physical limitations or disabilities?... yes no

C. Surgeries:

Did you ever have an operation? .... yes no

Please list____

D. Allergies

Have you ever had hives or other allergic reaction to foods or drugs.. yes no

Please list____

E. Exposures

Have you ever had a SIGNIFICANT exposure to:

High level noises... yes no	Formaldehyde ....yes no
Asbestos .... yes no	Ethylene Oxide ....yes no
Chemotherapy drugs....................................... yes no	Blood & body Fluids ....yes no
Comments:	Needle Puncture wound ....yes no

____

F. Personal History:

Medication now taking____

Do any of these medications affect your skills?.. yes no

Have drugs/alcohol ever been a part of your lifestyle? .... yes no

Have you ever been treated for drug or alcohol dependency? .... yes no

If yes, when and how treated?____

Have you ever had any fractures, serious injury or been knocked unconscious? .... yes no

If so, please describe____

Have you ever been rejected for life insurance, military service, employment, or disability insurance? ....yes no

List

____

Are you subject to any limitations in terms of activity or work? .... yes no
List ____________________

G. Past Medical History:

Have you ever had?

- Anemia .... yes no
- Diabetes .... yes no
- Epilepsy-seizures .... yes no
- Kidney disease .... yes no
- Immune system disorder .... yes no
- Nervous breakdown .... yes no
- Pneumonia .... yes no
- Rheumatic fever .... yes no
- Stroke .... yes no
- Arthritis .... yes no
- Heart Attack .... yes no
- Cancer .... yes no
- Lymphatic System disorder .... yes no
- Blood disorder .... yes no
- Varicose veins .... yes no

H. Family History:

Has anyone related to you ever had?

- Diabetes? .... Yes no
- Cancer? .... Yes no
- High blood pressure? .... Yes no
- Heart disease? .... Yes no

Are your parents living?

- Father? .... Yes no
- Mother .... yes no
- If no, give cause of death ____________________

Are your parents in good health? .... Yes no

If no, give problem ____________________

I. Ears:

Are you hard of hearing? .... Yes no

Do you have ringing in your ears? .... Yes no

Do you have frequent or?
chronic ear infections .... yes no

J. Neck:

Have you had thyroid trouble? .... Yes no

Do you have frequent swollen
glands in the neck? .... Yes no

K. Dermatologic:

Do you have frequent skin rash or itching? .... Yes no

Have you detected any lumps? .... Yes no

Have you ever had eczema
on hands or face? .... Yes no

L. General:

Are you frequently ill? yes no

Do you get spells of exhaustion? .... yes no

Do you have periodic fever, chills,
or night sweats? .... yes no

Are you considered a nervous person? .... yes no

Have you ever had a problem with
depression? .... yes no

Have you ever attempted suicide? .... yes no

Did you ever have a tumor, growth,
or cancer? .... yes no

Have you ever had or now have?

- Blood clots? .... yes no
- Blood vessel disorder? .... yes no
- Thrush, yeast, fungus infections? .... yes no
- Dental problems? .... yes no
- Liver, pancreas problems? .... yes no

M. Head:

Do you have frequent or
severe headaches? .... yes no

Have you had fainting spells,
dizziness, or blackouts? .... yes no

N. Eyes:

Do you wear glasses? .... yes no

or contacts? .... yes no

Do you have glaucoma? .... yes no

Has there been a change in your
vision recently? .... yes no

Date of last eye exam ____________________

Are you color blind? .... yes no

O. Nose and Throat:

Do you have frequent sore throats? .... yes no

Do you have hay fever? .... yes no

Do you have frequent sinus problems? .... yes no

Do you have frequent or
chronic hoarseness? .... yes no

P. Genitourinary:

Have you had kidney stones? .... yes no

Have you had frequent kidney

Q. Please bring a printed list of all current medication/s prescribed by your physician.

Latex Sensitivity Screening Form– SPC Vocational Nursing Program-Plainview Center

APPLICANT'S NAME: ___________________________________ DATE: __________________

Check Yes or No for each of the following. If an allergy is identified, please refer to your Health Care Provider.

	Yes	No
Do you currently wear latex (rubber) gloves regularly? If so, indicate why and how often? Why?______________________ How often_______________________		
Have you in the past worn latex gloves regularly? If so, why and how often? Why?______________________ How often_______________________		
Have you previously worked in the health care, electrical or food handling industry? If so, How long?____		
Do you have a history of frequent surgeries or invasive medical procedures?		
Do you have a history of eczema?		
Do you have a history of hand rashes? If so, when? ____		
Do you have a rash, itching, cracking, chapping, scaling, or weeping of the skin when wearing latex gloves?		
If symptomatic have you tried non-latex gloves?		
If so, did the symptoms get better or did they persist?		
When you are around persons who are wearing gloves, do you get hives, swollen lips or mucous membranes, have difficulty breathing, or any other respiratory symptoms?		
When you wear latex gloves do you get red, itchy, swollen hands or develop blisters on the hands within 30 minutes?		
Have you ever had an anaphylactic reaction to anything?		
Have you ever experienced shock during an operation?		
Do you have itching, swelling or any other symptoms following dental, rectal, or pelvic exams?		
Have you ever had difficulty breathing or swelling of the tongue, lips, or face after blowing up a balloon?		
Have you ever had itching, swelling or discomfort following exposure to rubber bands, rubber racquet handles, or elastic clothing bands?		
Have you ever had itching or swelling following the use of a condom or diaphragm?		
Do you have a history of hay fever?		
Do you have a history of asthma?		
Do you have a history of other respiratory allergies?		
Do you have a history of food allergies?		
Circle the foods below that cause you to have hives, itchy lips/throat, or other symptoms while eating or touching the food items. Apple Cherry Melon Pear Apricot Chestnut Nectarine Pineapple Avocado Fig Papaya Plum Banana Grape Passion Fruit Potato Carrots Hazelnut Peach Tomato Celery Kiwi Peanuts Other____		
Do you have a history of other allergies? If so, specify.		

Please discuss any identified allergies or concerns with your health care provider

South Plains College – Plainview Center
Vocational Nursing Program
Medication Form

STUDENT FULL NAME: ____

LAST FOUR STUDENT ID #__________________

LAST FOUR SOCIAL SECUIRTY # ____________

DATE OF BIRTH: ________________

PHONE____________________________ AGE: _____ SEX: ______

PHYSICIAN: ____

Please have your **physician** or health clinic complete the following data.

List all prescription medication currently taken by patient.
Patient's Name ___________________________________ Date of Visit _________________

Medication List:

a. **Name (brand and generic name):** ____
   Strength: _____________ Dose: _________________ Frequency: ___________ Route: _________
b. **Name (brand and generic name):** ____
   Strength: _____________ Dose: _________________ Frequency: ___________ Route: __________
c. **Name (brand and generic name):** ____
   Strength: ______________Dose:_________________ Frequency: ___________ Route: __________
d. **Name (brand and generic name):** ____
   Strength: ______________ Dose: _________________ Frequency: ___________ Route: _________
e. **Name (brand and generic name):** ____
   Strength: ______________ Dose: _________________ Frequency: ___________ Route: _________
f. **Name (brand and generic name):**____
   Strength: ______________ Dose: _________________ Frequency: ____________ Route: ________

General Assessment Attestation:

In your opinion, is this individual in suitable physical, mental and emotional condition for training in the Vocational Nursing Program?

Yes________________________ No________________________

______________________________ ______________________________
Signature of Physician Physician's Name (Please Print)

____________________________________ _________________________________
Physician's Address Physician's Phone Number Date

_____________________________ __________________________________
Student Signature Students Name (Printed) Date

CHECKLIST FOR YOU TO KEEP

Student ID number____________________

TSI Compliant: Y ☐ N ☐

TEAS Status: Reading, English, and Math 58.7 or higher and Science (points awarded based on score): Y ☐ N ☐

Cumulative GPA 2.0 or higher ________

Email address_________________________

(Use preferred email address you check daily)

- The Nursing program will require all Transcripts for all colleges and universities attended attached to the application.
- American Heart Association CPR Certification.

After acceptance into the program, do the following:

- Check your financial aid early & frequently with the financial aid office at least by the week of registration.
- Check your SPC Texan connect for any sudden changes.
- If you change marital status or have a name changes you will need to make changes with Admissions, then make changes with the Nursing Department

SOUTH PLAINS COLLEGE VOCATIONAL NURSING PROGRAM

ESTIMATED PRICE LIST (SUBJECT TO CHANGE)

A computer with a webcam and internet access is required while enrolled in the VNSG Program.

ORIENTATION:

- Uniforms $250-$300 White Shoes $50-$75 Bandage Scissors $5-$20 Penlight $5 Stethoscope $35-$50
- Admission finger printing approximately $50
- Admission Drug Screen $50

OTHER ITEMS NOT INCLUDED IN THE ABOVE ESTIMATE:

- CPR (required every 2 years) $60
- Physical exam and immunizations
- Watch with second hand. No smart watches in lab or clinical.

FIRST SEMESTER: $5677

- Tuition = 16 hours only = $4277 (nursing classes only)
  ** Tuition cost varies for In-district, Out-of-district or Non-resident.
- Required Textbooks New approx. $1400
  ** Textbooks used throughout the entire VNSG program

SECOND SEMESTER: $3938

- Tuition: 16 hours = $3938 (nursing classes only)
  ** Tuition cost varies for In-district, Out-of-district or Non-resident.

THIRD SEMESTER: $3743

- Tuition = 16 hours = $3743 (Nursing Classes Only)
  ** Tuition cost varies for In-district, Out-of-district or Non-resident.

Prior to graduation, you will have these estimated additional costs:

- State Board fee $100
- NCLEX-PN Exam fee $200
- Nursing pin $40
- Nursing lamp $27

TOTAL PROGRAM COST (ESTIMATE & SUBJECT TO CHANGE)

In-district $ 8,850
Out-of-district $14,335

NOTE: for specific program costs go to:
http://www.southplainscollege.edu/admission-aid/paying-for-school/tuitionfees.php