

SNAPP
*School Nurses as Professional Partners: Supporting Educational Outcomes
 for Students with Low-Incidence Disabilities*

Application Form*

A. General Information

Date ___/___/___

 Name

 Daytime Phone

 Street Address

 Evening Phone

 City/State/Zip

 FAX #

 Social Security Number

 E-Mail

 Date of Birth

 Country of Citizenship

 Current place of employment, if applicable

B. Educational Background

1. I have a BS ___ MS ___ degree in Nursing from _____
 (Name of College or University)

2. I am currently enrolled in a
 _____ Baccalaureate nursing program _____ RN to BS program
 _____ RN to MS program _____ other

 (Name of College/ University School of Nursing in which you are enrolled)

3. I plan to enroll in _____ or have submitted an application to _____

 (Name of College/ University School of Nursing)

I grant the Partnership for People with Disabilities permission to share this information with my university school of nursing. I give permission to my university school of nursing to provide enrollment and academic information to the Partnership as part of the application review process.

 Signature

 Date

