

# 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

October 20, 2005

