Southern Connecticut State University  
Department of Nursing  
Nursing Program Disclosure Form

SECTION I: APPLICANT INFORMATION
First Name: _________________________  Middle Initial: _______  Last Name: __________________________

Date of Birth: _____/_____/_______  Previous Name(s): ___________________________________________

Email Address: ___________________________________  SCSU Nursing Program you are applying to: _____ BSN   _____ ACE

Previous College/University Nursing Program Attended: __________________________  Dates: ____________________

I authorize the release of the information requested below:

__________________________
Signature of Applicant

__________________________
Date

SECTION II: COMPLETED BY NURSING DEAN, PROGRAM CHAIR/DIRECTOR, OR SIMILAR OFFICIAL ONLY

1. Has this student been enrolled in a nursing program at your institution?
   _____ YES   _____ NO  (If NO, please sign this form below and return per instructions at the bottom.)

2. Has this student been involved in any disciplinary action at your school, or are there any cases pending?
   _____ YES   _____ NO  If YES, please explain:
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________________________________________________

3. Is this student currently eligible to return to your nursing program?
   _____ YES   _____ NO  If NO, please explain:
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________
   ____________________________________________

4. Are there any factors (academic, social, or other) that would interfere with the student’s ability to make normal progress toward his/her degree?
   _____ YES   _____ NO  If YES, please explain:
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________
   ____________________________________________

5. If there is additional information you would like to include, please include a separate document with this form.

Name of Official  
Title  
Phone Number

__________________________
Signature

__________________________
Date

This form must be completed by the Nursing Dean/Director/Coordinator and returned by the Nursing Dean/Director/Coordinator directly to Chelsea Ortiz, Associate Director of Nursing Admissions, Enrollment Management, and Communication (PabonC1@southernct.edu), fax (203) 392-6493, or mail at:

SCSU, Department of Nursing  
ATTN: JE135, Chelsea Ortiz  
501 Crescent Street  
New Haven, CT 06515

Updated January 2022