



**Graduate Programs of Nurse Anesthesia
Doctorate of Nurse Anesthesia Practice
1201 Wesleyan Street
Fort Worth, Texas 76105-1536
<http://www.txwes.edu/nurseanesthesia/index.htm>**

(\$50.00 Application Fee) Anticipated Semester of Enrollment: Fall/Spring/Summer 20_____

Name: _____
Last First MI (Maiden) Social Security Number

Address: _____
Street City State County Zip Code

Telephone: Home () _____ Work () _____ Cell () _____

Email address: _____ Male _____ Female _____ Date of Birth ____/____/____

The information below is voluntary and will be used in a nondiscriminatory manner, for federal and/or state law reporting, consistent with applicable civil rights laws.

Religious Preference _____

Racial/Ethnic Origin:

___ Black/African American ___ American Indian/Native American ___ Asian ___ Pacific Islander ___ White, Caucasian
___ Hispanic, Latino, Hispanic American Other, please specify: _____

U.S. Citizen? ___ Yes ___ No If not, country of citizenship _____

List ALL Universities attended including Texas Wesleyan University. If your transcript(s) contains a name other than the one listed above, please inform us in order to prevent the transcripts(s) from being misplaced.

SCHOOL	DATES ATTENDED	DEGREE	OTHER NAME(S)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SEMESTER DATE OF LAST COURSE COMPLETED: _____
_____ Chemistry _____ Statistics _____ Research

EMPLOYMENT INFORMATION:

Please check all that apply

- Self employed
- Hospital employee
- MD group employee
- CRNA group employed
- University employee
- Other - Please specify: _____
- Currently in management
- Currently in education

Please list names of people submitting references:

Supervisor/Colleague: _____ Personal: _____
 (Able to attest to applicant’s clinical skills/work ethic) (Able to attest to applicant’s integrity/character)

Academic Instructor: _____ Other: _____
 (Able to attest to applicant’s academic ability and aptitude for advanced learning)

A copy of your current Council on Certification or Council on Recertification card must be submitted along with this application.

I affirm that all of the information on this form is complete and accurate to the best of my knowledge. I understand that falsifying this application will be cause for rejection or dismissal.

Signature: _____ Date: _____

Please submit written responses to the following (Type, single spaced):

- A. Describe what knowledge/skills you expect to receive from the DNAP program. Please identify if you plan on pursuing either the education focus or the management focus courses and how you see this knowledge benefiting your current practice or future goals.
- B. Please comment on the following statement: *"The accrediting arm of the **American Association of Colleges of Nursing** desires that all advanced practice nurses possess a practice doctorate degree or better for entry into practice by 2015. The **American Association of Nurse Anesthetists** supports the practice doctorate degree for entry into practice by 2025."*