Delta College

VALIDATION APPLICATION FOR HEALTH PROGRAMS

Date: _____/_____/_____ **This application will be reviewed for the current semester.**

Student Number _____

Name _____
            LAST   FIRST   MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Other Phone _____

Do you have transfer credits from another college or university? ☐ Yes ☐ No

If yes, **has Delta College received your official transcripts to evaluate your transfer credits**? ☐ Yes ☐ No

If no, please indicate the date you intend to submit your official transcripts to Delta College: _____

Do you have any approved course waivers or substitutions? ☐ Yes ☐ No If yes, indicate below the course(s):

Course(s) _____

PROGRAM (Check one program *only*)

☐ Dental Hygiene – VL.20001
☐ Nursing, RN Full-Time – VL.20002
☐ Nursing, RN Part-Time – VL.20012
☐ Nursing Transition LPN – VL.20003
  ○ **Valid Practical Nurse License**

☐ Nursing Transition Paramedic – VL.20004
  ○ **Valid Paramedic License**
☐ Physical Therapist Assistant – VL.20006
  ○ **Observation Form**
☐ Practical Nurse – VL 35005

☐ Radiography – VL.20007
☐ Respiratory Care – VL.20008
☐ Surgical Technology (Associate) – VL.20010

Important: Additional forms/proof of licensure required by Nursing Transition LPN/Paramedic and Physical Therapist Assistant programs <u>must be handed in with your validation application.</u>

NOTE : Sonography (DMS) – Turn in application packet to Program Coordinator.

☐ **I have read and understand the following to be my responsibility:**

I have been admitted to Delta College and accept full responsibility for completing all current program requirements and for following all validation, registration, and program policies and procedures. (I must see my Program Coordinator for **CPR, Health Form**, and **Observation Form** completion requirements.) Delta College reserves the right to change program requirements and procedures.

It is my responsibility to make sure all requirements (including **waivers**, **substitutions**, **incompletes**, etc.) are met before the last date of the semester and that **transfer credit** is received within two weeks from the last date of the semester.

I am responsible: 1) to obtain information regarding the 1st year Clinical Entry registration/waitlist process for my health program, **2)** to complete the process during the duration of my validation period (normally 3 years).

I understand that if my program fills and I do not get in within the given 3 year time frame, I must contact my program coordinator to request an extension to my validation status. This extension will only be considered if I have completed the registration/waitlist process during my designated Health Program registration period for all available semesters.

Submission of this application voids any previous application/validation. _____
                                                     Student Signature