

**SHASTA COLLEGE HEALTH SCIENCES AND UNIVERSITY PROGRAMS
VOCATIONAL NURSING (VN) PROGRAM
APPLICATION PACKET FOR *Spring 2027*
COHORT**

PLEASE PRINT IN INK

Name: _____ ID# _____
(Last) (First) (MI)

Vocational Nursing application packets for Spring 2027 will be accepted **Monday, September 8, 2026, through 4:00pm, Friday, September 28, 2026** in the Shasta College Health Sciences Division Office. **Please print all applications single sided.**
Mailed applications must be postmarked within the application period.

PACKETS WILL NOT BE ACCEPTED OUTSIDE OF THE APPLICATION PERIOD

COLLECT THE OFFICIAL DOCUMENTS REQUIRED AND SUBMIT WITH APPLICATION IN A SEALED ENVELOPE.
Additional documents will not be accepted after submission of the application packet.

Mail or hand deliver to: Shasta College Health Sciences Division, 1400 Market Street, Suite 8204, Redding, CA, 96001

The following items are MANDATORY and must be included in the Application Packet.

COMPLETED/ENCLOSED:

YES N/A

☐

Spring 2027 Vocational Nursing Program Application Packet – (3 pages)

☐

Application Immunization Documentation Checklist (2 pages)

☐☐

OFFICIAL* High School Transcript showing the date of graduation, official transcript for completion of California High School Proficiency Examination (CHSPE) or HISET exam, or official transcript of G.E.D test results or certificate.

❶ Official high school transcript, official CHSPE or HISET results, or official transcript of G.E.D test results are not necessary if applicant has a post-secondary degree and submits the official College Transcript showing the conferred degree. No copies of degrees, diplomas, certificates, or transcripts will be accepted.

☐☐

OFFICIAL* Advanced Placement (AP) or CLEP test scores if using to satisfy graduation/prerequisite requirements or proficiency in languages other than English (if applicable).

☐☐

OFFICIAL* College Transcript from all colleges ever attended where work was attempted or classes were completed, except for Shasta College. If general education or prerequisite courses were not taken at a California Community College, please include syllabi from the other college(s) courses in your application packet.

NOTES:

- OFFICIAL RECORDS/TRANSCRIPTS are those that have been issued by another educational institution.
 - Physical transcripts must be submitted in your sealed application packet. **DO NOT SUBMIT PHYSICAL TRANSCRIPTS TO ADMISSIONS & RECORDS.** Transcripts must be in a sealed envelope and remain unopened to be considered official. **DO NOT OPEN.** If an envelope has been opened (seal broken) prior to putting it in your application packet, it cannot be accepted for the purpose of application to the VN Program.
 - Electronic transcripts must be sent to admissions@shastacollege.edu, and you must include a copy of the receipt from your transcript request transaction with your application packet.
- It is not necessary to submit an official Shasta College transcript; a transcript of your Shasta College courses will be obtained from the Admissions & Records Office and made an official part of your application packet.
- All other College and/or high school records that may already be on file with the Shasta College Admissions & Records Office cannot be used for this application packet. You must resubmit all college and/or high school records with each new application packet.

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COMPLETED/ENCLOSED:

YES N/A

ONE OF THE FOLLOWING:

- | | | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Copy of your current state issued Nurse Assistant certificate that shows your certificate number, date of issue and expiration (if applicable). This must be current at the time of application. |
| ☐ | ☐ | Copy of your Shasta College Medical Assisting certificate that has been issued within the last 3 years. |
| ☐ | ☐ | A completed Work Experience Verification Form showing employment with healthcare experience (>200 hours, with direct human care/contact, within the last 3 years) |

Applicant Statement:

I hereby certify that all materials presented, and all statements made are true and correct. I authorize investigation of all records submitted and am prepared to provide original documentation when requested. I understand that any misrepresentation of material facts may be cause for immediate disqualification.

Furthermore, I understand and acknowledge that failure to meet requirements or omission of required documentation will result in disqualification of my application packet.

Signature of Applicant: _____ Date: _____

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APPLICATION DEADLINE: 4 P.M. Friday, September 28, 2026

SHASTA COLLEGE ID NUMBER:	SHASTA COLLEGE EMAIL ADDRESS (REQUIRED FOR ALL APPLICANTS):	BIRTHDATE:
NAME (Last, First, M.I.):		TELEPHONE:
ALL OTHER NAMES UNDER WHICH YOU HAVE BEEN KNOWN:		ALT. PHONE:
CURRENT ADDRESS:		
Street	City	State Zip
NAME AND LOCATION OF HIGH SCHOOL LAST ATTENDED: _____		
HIGH SCHOOL GRADUATE: () YES () NO; EQUIVALENT: () G.E.D. () HIGH SCHOOL PROFICIENCY; COLLEGE: () AA/AS () BA/BS () MASTERS/PhD		
ARE YOU A VETERAN? () Y () N If yes, did you receive medical training while in the service? (Explain type of training) _____		

LIST ALL COLLEGES AND UNIVERSITIES ATTENDED, INCLUDING SHASTA COLLEGE (Use an additional sheet if needed):

NAME OF COLLEGE	LOCATION	UNITS COMPLETED (indicate Quarter or Semester)	Dates Attended FROM/TO	DEGREE
		☐ Q ☐ S		
		☐ Q ☐ S		
		☐ Q ☐ S		

All courses listed must be completed prior to applying to the Vocational Nursing Program.

If courses were not taken at Shasta College, include syllabi from college(s) attended.

PREREQUISITE COURSES	NAME OF COURSE	NAME OF COLLEGE	COMPLETED Term & Year	GRADE
BIOL 5 – Human Biology				
BIOL 6 – Human Biology Lab ☐ I have taken Anatomy & Physiology and wish to substitute those courses for BIOL 5 & 6				
PSYC 1A – General Psychology OR PSYC 14 – Psychology of Personal and Social Adjustment				
NUTR 25 – Nutrition				

SKILLS EXPERIENCE

Enclosed is one of the following:

- ☐ A copy of your current Nurse Aide Certificate from the state (must current at time of application to the VN program).
- ☐ A copy of your Shasta College Medical Assisting certificate that was issued within the last 3 years
- ☐ Work Experience Verification form



Name _____

Student ID # _____

Indicate program of application:

- ☐ Associate Degree Nursing (ADN) ☐ Dental Hygiene ☐ Physical Therapist Assistant ☐ Vocational Nursing

For ADN, Dental Hygiene, and Physical Therapist Assistant students **only**, mark one of the boxes below:

- ☐ I am a previously **continually** qualified applicant and wish to use the immunization/titer documents from my last application.
- ☐ I am **not** a previously continually qualified applicant and understand that I must follow the directions below.

Directions: Complete all the sections below and **attach copies of your official immunization & titer documentation**. Immunity to infections may be documented by either vaccine administration or a positive titer. Vaccines and titers offer the most objective documentation and protection for the student and institution.

Titer Requirements

- **Titers must show positive immunity.** Titers showing negative/equivocal/gray-zone results do not meet program requirements.
 - **Quantitative** titer results are preferred. All titers must show patients full legal name, date of birth, collection date, lab/doctor's information, name of test, and the numerical values used in interpreting the results (reference range), with the results. Quantitative titers need to be "Surface AB (Antibody) IgG", **NOT** AG (antigen) or Core IgM or ACIF. Titer results don't expire.
 - **Qualitative** titers will be accepted although Quantitative titers are preferred. Qualitative titers simply indicate "immune vs. non-immune" or "reactive vs. non-reactive" (with no numerical value). Titer must show full legal name, date of birth collection date, lab/doctor's information, name of test, and the result.
 - If your results come back negative, see the "*Options" section for that requirement to determine what steps to take next.
- ① For applicants deemed "non-converters" by their primary healthcare provider, provide proof of ALL vaccination & titer records as well as a letter from the provider confirming non-converter status.

Tetanus, Diphtheria, Pertussis (Tdap) - must show documentation of either A or B:

- A.** One time dose of Tdap (includes pertussis) as an adult **within** the last 10 years (exp; 4/4/2014 expires 4/4/2024)

Date _____

- B.** Proof of Tdap older than 10 years **AND** proof of Td booster within the last 10 years

Tdap date _____ Td date _____

Varicella - must show documentation of either A or B:

Note: A previous diagnosis of chickenpox is **NOT** accepted as proof of Varicella immunity. Must submit documentation of either A or B as outlined below.

- A.** Two (2) doses of Varicella vaccine administered at least 4-8 weeks apart

Date #1 _____ Date #2 _____

- B.** Proof of either a *quantitative* IgG titer or proof of a *qualitative* titer showing **positive/immune** or **reactive**

Titer date _____ Numerical/Results _____

*If titer results show as **negative OR equivocal immunity**, see Option 1 or 2.

***Options for addressing negative or equivocal titer**

You must provide either:

- 1)** Proof of your original 2-dose vaccination series and having received one (1) booster after your negative titer

Original Series: Date #1 _____ Date #2 _____ Booster date: _____

OR

- 2)** if you have no previous records, proof of obtaining the 2-dose series after your negative titer

Series given: Date #1 _____ Date #2 _____

Measles, Mumps, Rubella (MMR) - must show documentation of either A or B:

A. Two (2) doses of MMR vaccine administered at least 4-weeks apart

Date #1 _____ Date #2 _____

B. Proof of *quantitative* IgG titer showing **positive/immune** to Measles, Mumps, and Rubella

Titer date(s) _____

Numerical value - Measles (Rubeola): _____

Numerical value - Mumps: _____

Numerical value - Rubella: _____

****If titer results show as negative OR equivocal immunity, see Option 1 or 2.**

***Options for addressing negative or equivocal titer**

You must provide either:

- 1)** Proof of your original 2-dose vaccination series and having received one (1) booster after your negative titer

Original Series: Date #1 _____ Date #2 _____ Booster date: _____

OR

- 2)** if you have no previous records, proof of obtaining the 2-dose series after your negative titer

Series given: Date #1 _____ Date #2 _____

Hepatitis B: Must submit proof of *quantitative*, IgG surface antibody titer showing **positive/immune**

Titer Date: _____

Numerical Value: _____

If you have a titer drawn and the numerical value for titer falls in the "grayzone"/borderline/equivocal range or non-reactive/negative range, you will need to:

- 1)** Receive **at least** one (1) booster of the vaccine. Discuss with your healthcare provider if your titer results indicate that you may need multiple boosters or to repeat the entire series. **PLEASE START THIS IMMEDIATELY.**

Note: If three dose vaccine series is needed, the CDC standard recommendations are for the series to be given at 0, 1, and 6 months. CDC minimum requirements allow for the series to be given at 0, 1, and 4 months.

- 2)** Obtain a new titer for Hepatitis B [surface antibody IgG] at least 4 weeks after the final booster/dose and **submit the results showing positive/immune.**

For Health Sciences Division Use Only:

Date Received:

Immunization official documentation verified by:

Notes:

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Work Experience Verification Form

Work experience must be for more than 200 hours with direct human care/contact within the last 3 years.

In order to receive credit towards work experience, submit this form along with a formal letter on letter head from each of your current and/or former employer(s)/organization(s) meeting the requirements below. To use work experience from more than one employer/organization, a separate form must be submitted for each.

For Work Experience with Direct Human Care/Contact: The letter must be on organization letterhead with an original signature and include the applicant's name (must match name on application), start date and end date (if applicable), employment status, (full-time/part-time), number of hours worked per week (or total hours worked from/to date), job title, department (if applicable), and examples of duties including patient interaction.

This verifies that I, _____, was an employee at
(Name of Applicant)

_____ located at _____
(Name of firm, agency, etc.) (Address of firm, agency, etc.)

_____ (Address continued) _____ (Phone number)

From _____ to _____ for a total of _____ hours.
(Date) (Date)

Name of Supervisor:

I understand and acknowledge that this form as well as the required **additional documentation** as described above must be enclosed in my application packet. I hereby acknowledge that the omission of the required materials will result in disqualification of my waitlist application packet.

Student Signature: _____ Date: _____