Demographic Form
Doctor of Nursing Practice
University of North Carolina Wilmington School of Nursing

Name

____________________  ____________________  ____________________
Last           First          Middle

Residence: Address

__________________________
Street

City       State       Zip       County       Country

Employment: Address

__________________________
Street

City       State       Zip       County       Country

Home Phone ____________________ Work Phone ____________________

Social Security Number* ____________________
*Disclosure of your Social Security number is purely voluntary. It will be used for administrative purposes only, as your assigned identification number.

Gender**          Male           Female

Birthday**  (Month/Day/Year) ____________________
**Information requested only for reporting purposes.

Semester/Year of Expected Entrance ____________________

Full Time   (or)   Part Time

1. Do you have demonstrable computer skills, including ability to use electronic mail, a web browser, and a word processing program?
   Yes   No

   Do you own a computer?
   Yes   No

   If Yes, indicate type, amount of RAM, size of hard-drive, modem capabilities, programs installed, etc.
   ____________________
   ____________________
   ____________________

2. Do you have access to a computer in close proximity to where you will study?
   Yes   No   e-mail address ____________________

3. The Federal government requires institutions of higher education receiving federal assistance to report minority group student enrollments. The information requested here will assist in meeting this requirement and will provide statistical data for the university. Please check the appropriate line:

   American Indian or Alaskan Native
   White (Not of Hispanic Origin)
   Black (Not of Hispanic Origin)
   Asian or Pacific Islander
   Hispanic
   Other (Specify)
4. Is English your first (native) language? ______ Yes ______ No. What language(s), other than English do you speak? ________________.

5. Sigma Theta Tau membership, as an undergraduate? ______ Yes ______ No. Other honorary membership(s) (Specify) ________________________________________________.

NURSING EXPERIENCE:

1. Do you currently hold an active license to practice as a Registered Nurse? ______ Yes ______ No. If Yes; what state(s)? ____________________________.
   If Yes; Certificate number(s)? ________________________________________________________.
   Years of RN experience. Full Time ____________ Part Time ____________.

2. Type of agency in which you work/have worked: (Within the past two years, check all that apply.)
   [ ] Community Health Center  [ ] Physician’s Office
   [ ] County Health Department  [ ] Rural Health Clinic
   [ ] Hospital  [ ] School
   [ ] Occupational Health  [ ] School of Nursing
   [ ] Migrant Health Clinic  [ ] Nursing Home
   [ ] Other (Specify) ____________________________.

3. Population served/Nature of experience: (Check all that apply.)
   [ ] Infants; # of years ____________.
   [ ] Adults; # of years ____________.
   [ ] Children; # of years ____________.
   [ ] Elderly/Older Adults; # of years ____________.
   [ ] Women; # of years ____________.
   [ ] Pregnant Women; # of years ____________.
   [ ] Adolescents; # of years ____________.

4. Percentage of medically underserved and/or minority population(s) served: (Check all that apply.)
   [ ] Low income ____________%.
   [ ] Elderly ____________%.
   [ ] African Americans ____________%.
   [ ] Hispanics ____________%.
   [ ] Native Americans ____________%.
   [ ] Migrants ____________%.
   [ ] Other (Specify) ____________%.

I certify that the information on this survey is complete.

APPLICANT’S SIGNATURE ____________________________ Date ________________________.