# 2010 Application Checklist

## School of Nursing

## Entry-Level Nursing Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Application Fee</th>
<th>Resume</th>
<th>Official Transcripts</th>
<th>Recommendations</th>
<th>GRE</th>
<th>Prerequisite Checklist</th>
<th>Other Requirements</th>
<th>Essay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct-Entry Master of Science in Nursing (DEN)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td>✔</td>
<td>Satisfactory completion of prerequisite coursework</td>
<td>✔</td>
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<tr>
<td>Accelerated Bachelor of Science in Nursing (ABSN)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td>Not Req.</td>
<td>Satisfactory completion of prerequisite coursework</td>
<td>✔</td>
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<tr>
<td>Second Bachelors Degree Program</td>
<td>✔</td>
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</table>

**Legend:**

- ✔ = Required
- Not Req. = Not Required
School of Nursing

2010 Application Instructions &
General Admission Requirements

Entry-Level Nursing Programs

Please read the following instructions carefully. Your application for admission will be evaluated only after the Office of Student Affairs has received ALL required materials. It is your responsibility to be certain that all necessary materials have been received by the Office of Student Affairs prior to the deadline.

1. **APPLICATION FOR ADMISSION:** Applicants are asked to collect and submit all application materials, including sealed official transcripts and sealed recommendation letters in one envelope. Please make sure your full legal name is included on all materials being submitted.

Mail your application packet to the following address:

MGH Institute of Health Professions
Office of Student Affairs
PO Box 6357
Boston, MA 02114

Keep in mind that Federal Express and UPS mail cannot be accepted at a P.O. Box address. If you must send materials by express service, please send it to our street address, as listed below:

MGH Institute of Health Professions
Office of Student Affairs
36 1st Ave.
Charlestown Navy Yard
Boston, MA 02129

* We will acknowledge the receipt of all applications by email.

2. **$65 NON-REFUNDABLE APPLICATION FEE:**

   - Please make checks payable to the MGH Institute of Health Professions.

3. **APPLICATION DEADLINE:**

   **Direct-Entry Master of Science in Nursing (DEN):** January 10th for Fall entry

   **Accelerated Bachelor of Science in Nursing (ABSN):** November 1st for following Summer entry

^ Application materials arriving after the deadline may be considered at the discretion of the program admission committee and only if space is available.
4. **MINIMUM DEGREE REQUIREMENT:** A bachelors degree is required for entry into either program.

5. **RESUME:** Please submit a current resume or CV.

6. **OFFICIAL TRANSCRIPTS:** Applicants must submit official transcripts from all colleges and universities attended, even if a degree was not received from that institution. Include undergraduate and graduate course work. Sealed official transcripts should be mailed with the application packet. For courses in progress, transcripts should be forwarded upon completion.

   *Applicants who did not receive an undergraduate degree in the United States must have the degree transcript evaluated by an educational credentialing agency. When requesting a transcript evaluation, please request a “course-by-course” evaluation with grades (Preferred credentialing agencies are listed on our website).*

7. **RECOMMENDATION LETTERS:**

   Applicants are required to submit three letters of recommendation (Please be sure to print sufficient copies of the Recommendation Form if completing the paper application). Recommendation letters should come from individuals who are able to address your academic ability, leadership potential, character and integrity, as well as your potential for post-baccalaureate professional study. At least one letter should come from an academic reference and one should come from a professional reference.

8. **PERSONAL ESSAY:**

   **Direct-Entry Master of Science in Nursing (DEN)** - Essay should address the following questions:

   a. Tell us why you want to become a nurse practitioner or clinical nurse specialist.
   b. Tell us how past experiences and/or influences have contributed to your decision to become a nurse practitioner or clinical nurse specialist.
   c. What are your professional nursing goals and plans and how will your graduate nursing education at the MGH Institute of Health Professions help you to achieve those goals?

   **Accelerated Bachelor of Science in Nursing (ABSN)** - Express your reasons for wanting to enter the nursing profession. How do you view the role of nurses in the healthcare field?

   *Answers should be typed, double-spaced, and no more than three pages in total. Margins should be no more than one inch, and type size should be no smaller than 10-point, with 12-point type preferred. Please make sure your full legal name and the last four digits of your social security number are included on each page.*
9. **GRE (Graduate Record Examination):**

**Direct-Entry Master of Science in Nursing (DEN):** The GRE General Test is required for admission and must have been taken within the past 5 years. It is strongly recommended that the GRE be taken a minimum of eight weeks before our application deadline. Please keep in mind that your application file will be considered incomplete and may not be reviewed until after official GRE scores are received. **The MGH Institute of Health Professions school code is R3513.**

- **GRE Waiver Request:** The GRE test requirement may be waived, with program approval, if an applicant provides official documentation of having met one of the following criteria:
  1. Has taken an alternative test of preparedness for graduate-level studies acceptable to the Institute in its sole discretion, or
  2. Has already achieved a Master’s degree or higher

- To apply for a GRE waiver, applicants must submit the Institute’s **GRE Waiver Request Form** along with proper documentation. We strongly recommend that you submit this waiver request well ahead of the application deadline to allow time to take the GRE in the event your request is denied.

**Accelerated Bachelor of Science in Nursing (ABSN):** The GRE test is not required for entry into this program.

10. **PREREQUISITE COURSEWORK:**

**Direct-Entry Master of Science in Nursing (DEN):**

Completion of the following prerequisite courses with a grade of C or better is required for matriculation. All prerequisite courses should have been taken within five years of application*. Applicants may be asked to submit mid-term reports for certain prerequisite courses. Requests for prerequisite evaluations will be addressed in writing only. All prerequisites must be satisfactorily completed prior to matriculation.

- Human Anatomy
- Human Physiology
- Chemistry (including some Organic Chemistry)
- Microbiology
- Human Nutrition
- Statistics

The courses listed above may be taken at the MGH Institute of Health Professions as a non-degree student the summer prior to matriculation as part of our Science Prerequisites for the Health Professions Program. For more information and to register for courses, please refer to our website.

* Applicants may apply for a waiver of this policy by completing the **Prerequisite Time Limit Waiver Request Form**, which identifies the course(s) the applicant is asking to be waived from the policy along with qualifying rationale.
Accelerated Bachelor of Science in Nursing (ABSN):

Completion of the following prerequisite courses with a grade of C or better is required for matriculation. **All prerequisite courses should have been taken within five years of application***. Applicants may be asked to submit mid-term reports for certain prerequisite courses. Requests for prerequisite evaluations will be addressed in writing only. All prerequisites must be satisfactorily completed prior to matriculation. **Applicants may have one prerequisite course in progress the spring semester prior to matriculation.**

- Human Anatomy
- Human Physiology
- Chemistry (including some Organic Chemistry)
- Microbiology
- Human Nutrition
- Statistics

* Applicants may apply for a waiver of this policy by completing the *Prerequisite Time Limit Waiver Request Form*, which identifies the course(s) the applicant is asking to be waived from the policy along with qualifying rationale.

11. **TOEFL (Test of English as a Foreign Language):**
An official result of the TOEFL, taken within the last two years, is required of all applicants whose native language is not English. The minimum score requirement is 213 (computer-based test), 79-80 (Internet-based test) or 550 (paper-based test). Scores must be sent directly to the Institute by the testing service. This requirement is waived only if the applicant has received or expects to receive prior to enrollment, an undergraduate or graduate degree from a college or university in any of the following countries: The United States of America, New Zealand, and Canadian institutions where the language of instruction is English. A waiver may also be granted if a credentialing agency can show that the medium of instruction at the undergraduate or graduate institution where the degree was awarded was English. **The MGH Institute of Health Professions school code is R3513.**

12. **ADDITIONAL PROGRAM REQUIREMENTS:**

Direct-Entry Master of Science in Nursing (DEN) & Accelerated Bachelor of Science in Nursing (ABSN): Submit a completed *Prerequisite Checklist*

For additional information and access to all supplemental forms, please visit our website at [www.mghihp.edu](http://www.mghihp.edu).

**PROGRAM CONTACT INFORMATION:**

Email: nursing@mghihp.edu
I. PERSONAL INFORMATION

Are you currently an employee of the Partners Healthcare System? ____ YES  ____ NO 
If so, where are you employed? __________________________________________

LAST ________________________  FIRST ___________________________  MIDDLE ________________

Please list other names which may have previously appeared on academic records: ____________________________

Social Security # __________________________  Date of Birth ____ / ____ / ______ 
(for identification purposes only)  Month / Day / Year 

□ Male  □ Female

Current Address (valid until ______________): ______________________________________________________

Number    Street
____________________________________________________________________________________________________________________

City      State      Zip
___________________________________________

Current Phone: (       ) _____ - ________

Permanent Address: __________________________________________________________________________

Number     Street
___________________________________________________________________________       _______________________________________

City   State   Zip    Country
___________________________________________

Email Address: _________________________________ Permanent Phone: (       ) _____ - ________

II. CITIZENSHIP AND VISA INFORMATION

Are you a United States citizen? □ Yes  □ No 
If not, what country are you a citizen of? ____________________________

Do you hold Permanent Resident status? □ Yes  □ No   Alien Registration number: ________________________
(provide a copy of your card)

What is your expected visa status during your studies in the United States? □ F-1  □ Other          (type)

Are you a U.S. Veteran? □ Yes  □ No   If yes, are you receiving Veterans benefits? □ Yes  □ No
III. PROGRAM OF STUDY

Please check the academic program to which you are applying:

☐ Accelerated Bachelor of Science in Nursing (ABSN)  Summer entry only

☐ Direct-Entry Master of Science in Nursing (DEN)  Fall entry only

Select Specialization :

(First choice not guaranteed)

___ Acute Care (Nurse Practitioner Specialty)

___ Family (Nurse Practitioner Specialty)

___ Adult Primary Care (Nurse Practitioner Specialty)

___ Pediatrics (Nurse Practitioner Specialty)

___ Psych/Mental Health (Nurse Practitioner Specialty)

___ Dual Adult/Women’s Health (Dual Nurse Practitioner Specialty)

___ Dual Adult/Gerontology (Dual Nurse Practitioner Specialty)

___ Psych/Mental Health (Child/Adolescent) Clinical Nurse Specialist

___ Psych/Mental Health (Adult) Clinical Nurse Specialist

IV. EDUCATION

List all schools attended beyond high school, including schools at which you are currently enrolled. Please list schools chronologically (most recent first). GPA is required only from institutions where a degree was received.

<table>
<thead>
<tr>
<th>Name of College/University</th>
<th>Dates Attended</th>
<th>Degree</th>
<th>Major</th>
<th>GPA</th>
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</table>

Do you believe that your academic record accurately reflects your ability?  □ Yes  □ No

If not, please explain. Attach additional sheets if necessary.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

V. STANDARDIZED TESTS

Please refer to the application instructions for more detailed information regarding required standardized tests for your academic program.

NOTE: Official reports of GRE scores should be sent directly to the MGH Institute of Health Professions from the testing service (ETS). Our school code is R3513

Graduate Record Examination Scores (GRE):

Test Date: _____ / _____ / ______ Verbal:______ Quantitative: _______ Writing Assessment: _______

Month / Day / Year

Future Test Date: _____ / _____ / ______  (Test must be taken prior to the program’s application deadline)

Month / Day / Year
Applying for a GRE waiver? □ Yes □ No

Please see application instructions to determine eligibility. Students requesting a waiver must complete the GRE Waiver Request form.

Test of English as a Foreign Language scores (TOEFL):

Applicants whose native language is not English and/or who did not receive a degree from a college or university whose language of instruction is English must take the TOEFL. Test must have been taken within the past 2 years.

Test Date: ______ / _____ / ______  Test results: ____________________

Future Test Date: ______ / _____ / ______  (Test should be taken prior to the application deadline)

VI. WORK EXPERIENCE (Please include CV or resume)

Include honors, awards and publications or any professional organizations and/or community activities you have been involved in on your resume, if applicable.

VII. RECOMMENDATIONS

Please provide contact information in the space below for those who will be completing a recommendation form on your behalf:

1. Name: ____________________________________________  First

   Organization: ________________________________  Title: ________________________________

   Address: ________________________________  S t r e e t   C i t y   S t a t e   Z i p

   Email Address: ________________________________  Relationship to applicant: ________________

2. Name: ____________________________________________  First

   Organization: ________________________________  Title: ________________________________

   Address: ________________________________  S t r e e t   C i t y   S t a t e   Z i p

   Email Address: ________________________________  Relationship to applicant: ________________

3. Name: ____________________________________________  First

   Organization: ________________________________  Title: ________________________________

   Address: ________________________________  S t r e e t   C i t y   S t a t e   Z i p

   Email Address: ________________________________  Relationship to applicant: ________________
VII. APPLICANT AFFIDAVIT

I hereby certify that the information given on this application is complete and correct to the best of my knowledge, and that I have attended no institution other than those I’ve listed. I understand that all documents sent to the MGH Institute of Health Professions become the property of the MGH Institute of Health Professions and will not be returned to me or duplicated for any reason. I further acknowledge that the application fee only partially covers the cost of processing my application and that the fee is non-refundable. I understand that if I am accepted to the MGH Institute of Health Professions, my admission is contingent upon verification of all official records from the institutions I’ve attended, as well as satisfactory completion of all outstanding admission requirements. I understand that any misrepresentation or omission with regards to this application may result in refusal of admission or cancellation of registration. I understand that the MGH Institute of Health Professions reserves the right to rescind any and all acceptances to the institution.

Signature of applicant ______________________________

Date

It is the policy of the MGH Institute of Health Professions not to discriminate on the basis of race, color, creed, gender, gender identity or expression, sexual orientation, age, disability, veteran status, marital status, or national origin. The institute respects and values the diverse backgrounds of all people, and welcomes all students to fully participate in all the rights, privileges, programs, and activities generally accorded or made available to the Institute community. This policy incorporates, by reference, the requirements of Title VII of the Civil Rights Act, Title IX of the 1972 Educational Amendments, and all relevant federal, state, and local laws, statutes, and regulations.

In compliance with the Jeanne Clery Disclosure Act of 1998, MGH Police and Security provides information annually about crime statistics within our community. A copy of this information is available at the office of MGH Police and Security or at http://ope.ed.gov/security

OPTIONAL:

The MGH Institute of Health Professions provides equality of opportunity to all students. Ethnic and profile information is only used to complete reports required by the government and/or accrediting agencies. This information will not influence the Institute’s decision regarding admission.

Please indicate your primary ethnic background:

☐ Hispanic / Latino ☐ Non-Hispanic / Latino

Please indicate your primary racial background:

☐ Black or African-American ☐ American / Alaskan Native
☐ Hawaiian / Pacific Islander ☐ Asian
☐ White ☐ Other _____________________________
The Family Educational Rights and Privacy Act of 1974 and its amendments guarantee students access to educational records concerning them. Students are also permitted to waive their right of access to recommendations. The following signed statement indicates the wish of the applicant regarding this recommendation. Failure to respond will be considered a waiver of the right of access to this recommendation. This waiver is not required for admission.

____ I waive my right to inspect this recommendation
____ I do not waive my right to inspect this recommendation

Signature: _______________________________________________

INSTRUCTIONS FOR APPLICANT: Please fill out top section and forward to recommenders. Make sure to provide each recommender with a self-addressed, stamped envelope to expedite its return.

Name: _____________________________ Social Security Number (last 4 digits): ________________________

Program of study:  ____Communication Sciences & Disorders  ____Nursing  ____Physical Therapy
                     ____Medical Imaging  ____Teaching and Learning CAS

INSTRUCTIONS FOR RECOMMENDER:

Please complete and check off sections A and B and return the completed form in a sealed envelope with your signature across the seal to preserve the confidentiality of this document.

☐ A. Please provide a separate letter of recommendation that addresses the potential of the applicant to be a post-baccalaureate or graduate student, including any additional comments concerning maturity, critical thinking skills, ability to adapt to change, or any other factors that you think may be pertinent to the student’s performance in a professional curriculum. Additionally, it is important for us to assess the potential of each student to succeed in a clinical environment. If you feel qualified to make this assessment, please include your comments in this evaluation.

RECOMMENDER NAME: ___________________________________________________________________

TITLE: _____________________________ DATE: _____________________________

INSTITUTION/COMPANY TITLE: __________________________________________________________

ADDRESS: _____________________________ CITY: _______________ STATE: ______________

PHONE: ________________________________ EMAIL ADDRESS: __________________________

SIGNATURE: __________________________________________________________________________

RELATIONSHIP TO APPLICANT:  ____ ACADEMIC  ____ PROFESSIONAL  ____ OTHER

How long have you known the applicant? _________________________________________________
B. Please rank the applicant with respect to each category below:

<table>
<thead>
<tr>
<th></th>
<th>EXCELLENT</th>
<th>GOOD</th>
<th>AVERAGE</th>
<th>BELOW AVERAGE</th>
<th>NO BASIS TO JUDGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intellectual ability</td>
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<tr>
<td>Written expression</td>
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<tr>
<td>Oral expression</td>
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<td>Flexibility</td>
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<td>Ability to organize and apply information</td>
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<td>Problem solving skills</td>
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<td>Maturity and emotional stability</td>
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<td>Initiative and perseverance</td>
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<td>Curiosity</td>
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<td>Potential for (or actual) clinical competence</td>
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<td>Ability to handle stressful situations</td>
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<td>Ability to interact well with others</td>
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<td>Ability to accept constructive feedback</td>
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<td>Ability to work independently</td>
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<tr>
<td>Capacity for Graduate study</td>
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</tbody>
</table>

Overall Impression:

[ ] Strongly recommend [ ] Recommend [ ] Recommend with reservations [ ] Do not recommend

Thank you for taking the time to assist us through the application and evaluation process. Your input is valued and greatly appreciated.

*MGH Institute of Health Professions*
*Office of Student Affairs*
*PO Box 6357*
*Boston, MA 02114*
*(617) 726-3140*
School of Nursing

GRE WAIVER REQUEST FORM
(Complete only if applicable)

The GRE requirement may be waived, with program approval, if you meet one of the criteria listed below. To request a GRE Waiver, applicants must submit this GRE Waiver Request Form along with official supporting documentation. We strongly recommend that you submit this waiver well ahead of the application deadline to allow time to take the GRE in the event your request is denied.

PLEASE NOTE: Post-Professional Nursing program applicants looking to meet option # 3 must successfully complete with a grade of B or better one of the following required courses: Advanced Pharmacology (NS-739 or NS-738 Advanced Pediatric Pharmacology, as appropriate to specialty) or NP-715 Advanced Pathophysiology, plus a second graduate level course in the program to which you are applying.

Applicant Name: ______________________________________________________________

Mailing Address: ___________________________________________________________________

Email Address: ___________________________________________________________________

Last 4 digits of Social Security Number: __________________________________________

Program of study: __________________________________________________________

Term of Entry: ___________________________________________________________________

Please check one of the following options as the reason for which you are requesting your GRE requirement be waived:

1. _____ I have taken an alternative test of preparedness for graduate-level studies acceptable to the Institute in its sole discretion

2. _____ I have already achieved a Master's degree or higher

3. _____ I have successfully completed, with a grade of B or better, two or more courses at the Institute in the program to which I am applying, not including prerequisite coursework (this option is not available for DEN applicants)

Please attach required documentation to this form and submit along with application to:
MGH Institute of Health Professions, Office of Student Affairs, PO Box 6357 Boston, MA 02114

For Institute Use Only: Program Decision: _____ Approved _____ Denied

Program Signature: ___________________________________________________________

Date of Decision: ___________________________________________________________________

Admission Signature: __________________________________________________________
Name_________________________________ Last 4 digits of Social Security Number: ____________

Please fill out this form completely. If a course is in progress, indicate “IP” under “Grade.” If you plan to take a course at the Institute or elsewhere, please list the location under “School” and indicate “WT” (will take) under “Grade.” All entries will be crosschecked against official school transcripts; please be sure entries are correct. Use abbreviations as necessary. Submit this form as part of your application.

<table>
<thead>
<tr>
<th>Prerequisite</th>
<th>Course #</th>
<th>Course Title</th>
<th>Credits</th>
<th>School</th>
<th>Term/Year</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Anatomy</td>
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<tr>
<td>General Chemistry</td>
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<td>Microbiology</td>
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Some courses listed above may be taken at the MGH Institute of Health Professions as a non-degree student the summer prior to matriculation as part of our Science Prerequisites for the Health Care Professions Program. For more information and to register for courses, please refer to our website.

All prerequisite courses should have been taken within 5 years of application and must be satisfactorily completed prior to matriculation.

Questions regarding whether or not a course will satisfy our prerequisite requirements will only be addressed in writing. Please email the School of Nursing for more information: nursing@mghihp.edu

Return this form with your application materials to:

MGH Institute of Health Professions
Office of Student Affairs
PO Box 6357
Boston MA 02114

Thank you for your assistance.
MGH INSTITUTE OF HEALTH PROFESSIONS
Accelerated Bachelor of Science in Nursing
Prerequisite Checklist

Name____________________________    Last 4 digits of Social Security Number: ____________

Please fill out this form completely. If a course is in progress, indicate “IP” under “Grade.” If you plan to take a course at the Institute or elsewhere, please list the location under “School” and indicate “WT” (will take) under “Grade.” All entries will be crosschecked against official school transcripts; please be sure entries are correct. Use abbreviations as necessary. **Submit this form as part of your application.**

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</table>

Applicants may have **one** prerequisite course in progress the spring semester prior to matriculation. All prerequisite courses must be complete with official documentation submitted to the Office of Student Affairs prior to the first day of class in order to matriculate.

**All prerequisite courses should have been taken within 5 years of application and must be satisfactorily completed prior to matriculation.**

**Questions regarding whether or not a course will satisfy our prerequisite requirements will only be addressed in writing. Please email the School of Nursing for more information:** nursing@mghihp.edu

Please return this form with your application materials to:

**MGH Institute of Health Professions**
**Office of Student Affairs**
**PO Box 6357**
**Boston MA 02114**

**Thank you for your assistance**