



## Apprentice Program Application ADN (RN) or PN (LPN) – FALL 2024

### Subject: Opportunity- Apply for the Nursing Apprenticeship Program!

Dear RN/LPN Nursing Students,

We hope this message finds you well and thriving in your studies. As the new semester approaches, we are excited to extend an invitation to all nursing students who will be enrolled in PN or RN courses NUR 105/106 Summer semester to apply for our prestigious Nursing Apprenticeship Program.

### Why Join the Nursing Apprenticeship Program?

The Nursing Apprenticeship Program provides a unique opportunity for nursing students to gain invaluable hands-on experience in real healthcare settings. This program offers:

1. **Clinical Exposure:** Work alongside experienced healthcare professionals in diverse clinical environments.
2. **Skill Development:** Enhance your clinical and interpersonal skills, preparing you for a successful nursing career.
3. **Networking:** Build connections within the healthcare industry and open doors to future career opportunities.
4. **Professional Development:** Receive mentorship and guidance from seasoned nurses and educators.
5. **Enhanced Resume:** Boost your resume with practical experience that sets you apart in the job market.

**Application Deadline:** Midnight on July 20, 2024

Please note that late applications or incomplete applications (missing resume and transcript(s)) will not be accepted. Make sure to submit your application before the deadline to be considered for this exceptional opportunity.

### How to Apply:

1. Complete pages 1 -5 of the attached application in its entirety.
2. Attach all required documents:
  - Application
  - Resume
  - Transcript (unofficial)
3. Submit all files as one PDF by email under the subject of Fall 2024 Apprentice Application – Last Name. (Example: Fall 2024 Apprentice Application – COMPTON) to [mcompton@wallace.edu](mailto:mcompton@wallace.edu).
4. Ensure your application is submitted by midnight on July 20, 2024.

We encourage all eligible nursing students to take advantage of this chance to accelerate their nursing education and professional development. However, the goal is to get you placed at a facility where you will continue to work after graduation. If you have any questions or need assistance with the application process, please don't hesitate to reach out to our WCCD Apprenticeship Program Office at [mcompton@wallace.edu](mailto:mcompton@wallace.edu) - ext. 6822 or [jlinder@wallace.edu](mailto:jlinder@wallace.edu) – ext. 2561

We look forward to receiving your applications and working with you on this exciting journey toward becoming a skilled and compassionate nurse.

Sincerely,

A handwritten signature in cursive script that reads 'Martha B. Compton'.

### **Martha Compton**

Associate Dean, Career and Technical

Office: 334.556.6822

Cell: 850.849.9115

[mcompton@wallace.edu](mailto:mcompton@wallace.edu)



## Apprentice Program Application Current WCCD Students

Apprenticeship for which you are applying:		
Application Date:	Wallace Student ID:	
First Name:	MI:	Last Name:
Street Address:		
City:	State:	Zip Code:
Mailing Address (if different from above):		
Phone:	Email:	
Emergency Contact Name:		Emergency Phone:
Date of Birth (mm/dd/yyyy):	Age:	US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible Non-Citizen
Ethnicity/Race (Check all that apply): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Does not declare a race		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Self-Identified	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran Dependent/Spouse/Widow: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>EDUCATION</b>		
Current College Program:		GPA:
Number of Completed Credit Hours:	Expected graduation/completion date:	
Do you have previous college certifications, degrees, or credits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
List any Career Technical or Industry Recognized Certifications previously earned:		
<b>PROGRAM ELIGIBILITY STATUS (Financial Aid)</b>		
Check any financial aid program for which you have applied or are currently receiving. (Check all that apply)		
WIOA ITA	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
PELL GRANT	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
STUDENT LOAN	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
VA BENEFITS	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
GI BILL	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
SCHOLARSHIP	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
WORK STUDY	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
VRS	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
TELAMON	<input type="checkbox"/> Applied	<input type="checkbox"/> Receiving
Other: _____		

<b>For Staff Use Only:</b> Reviewed By/Date: _____ Company: _____ Interview Date: _____
Financial Aid Referral: _____ Career Center Referral: _____ OJT Start Date: _____

**SCHEDULING / AVAILABILITY**

Please check the preferred days and times for class and work.

**CLASS:**  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

What times do you prefer?  Morning  Afternoon  Night

**WORK:**  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

What shifts are you available to work?

Day (List hours) \_\_\_\_\_ Evening (List hours) \_\_\_\_\_ Night (List hours) \_\_\_\_\_

Do you have a valid driver's license?  Yes  No

If offered employment, do you have reliable transportation to work the shifts assigned to you?  Yes  No

**EMPLOYMENT (Start with most recent employer. List additional experience on separate sheet of paper or attach resume.)**

Employer Name:	City:	State:
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Job Title:	Start Date:	End Date:
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Supervisor's Name:	Supervisor's Phone:
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Duties:

Hours Per Week:	Starting Wage:	Current/Ending Wage:
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Employer Name:	City:	State:
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Job Title:	Start Date:	End Date:
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Supervisor's Name:	Supervisor's Phone:
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Duties:

Hours Per Week:	Starting Wage:	Ending Wage:
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Employer Name:	City:	State:
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Job Title:	Start Date:	End Date:
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Supervisor's Name:	Supervisor's Phone:
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Duties:

Hours Per Week:	Starting Wage:	Ending Wage:
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**REFERENCES**

Name:	Relationship:	Phone:
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Name:	Relationship:	Phone:
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I agree to allow the information in this application to be shared with sponsoring companies for the selection of candidates into the apprenticeship program.  Agree  Disagree

Student Signature: \_\_\_\_\_

Wallace Community College - Dothan will not discriminate against apprenticeship applicants or apprentices based on race, color, religion, national origin, sex (including pregnancy and gender identity), sexual orientation, genetic information, or because they are an individual with a disability or a person 40-years old or older. Wallace Community College - Dothan will take affirmative action to provide equal opportunity in apprenticeship and will operate the apprenticeship program as required under Title 29 of the Code of Federal Regulations, part 30.



**Wallace Community College**  
**ADN (RN) or PN (LPN)**  
**Apprenticeship Application**

This apprenticeship program requires a combination of on-the-job learning, plus nursing coursework, labs, and simulation at the Wallace Community College Campus at Dothan. Candidates must be flexible and have the ability to be in school for full semesters and on the job site for on-the-job learning. Apprentices are paid while on the job and while performing clinical hours. Apprentices are not paid for on-campus classes, skills labs, or simulations

If you so choose, you may voluntarily disclose whether you have a disability. A form will be provided for those choosing to disclose a disability. This information is for statistical purposes only and will be kept confidential. Your decision to disclose or not to disclose a disability has no bearing on your eligibility to apply for the apprenticeship program.

The sponsor will not discriminate due to race, color, religion, national origin, sex (including pregnancy and gender identity), sexual orientation, genetic information, disability, or age over 40 years. The sponsor will take affirmative action to provide equal opportunity in the apprenticeship and will operate the apprenticeship program as required under title 29 of the Code of Federal Regulations, part 30.

**Right to Equal Opportunity**

It is against the law for a sponsor of an apprenticeship program registered for Federal purposes to discriminate an apprenticeship applicant or apprentice based on race, color, religion, national origin, sex, sexual orientation, age (40 years or older), genetic information, or disability. The sponsor must ensure equal opportunity with regard to all terms, conditions, and privileges associated with apprenticeship. If you think that you have been subjected to discrimination, you may file a complaint within 300 days from the date of the alleged discrimination or failure to follow the equal opportunity standards with Josh Laney with the Alabama Office of Apprenticeship located at One Technology Court, Montgomery, Alabama 36116. The phone number is 334-280-4414 and the email address is info@alapprentice.org. You may also be able to file complaints directly with the EEOC, or State fair employment practices agency. If those offices have jurisdiction over the sponsor/employer, their contact information is listed below. The EEOC can be reached at 1-800-669-4000.

Student Name \_\_\_\_\_ A# \_\_\_\_\_

Please initial by the Healthcare facilities where you are interested in applying for an Apprenticeship:

<b>Spring 2023 Participating ADN (RN) Apprenticeship Healthcare Facilities</b>	<b>Spring 2023 Participating LPN Apprenticeship Healthcare Facilities</b>
Flowers Hospital 4370 W. Main Street Dothan, AL 36305 Initials_____	Flowers Hospital 4370 W. Main Street Dothan, AL 36305 Initials_____
Crowne Health Care 430 Rivers Avenue Eufaula, AL 36027 Initials_____	Crowne Health Care 430 Rivers Avenue Eufaula, AL 36027 Initials_____
Laurel Oaks Behavioral Health Center 700 E. Cottonwood Road Dothan, AL 36301 Initials_____	Laurel Oaks Behavioral Health Center 700 E. Cottonwood Road Dothan, AL 36301 Initials_____
	Medical Center Barbour 820 W. Washington Street Eufaula, AL 36027 Initials_____
Wiregrass Medical Center 1200 W. Maple Avenue Geneva, AL 36340 Initials_____	Wiregrass Medical Center 1200 W. Maple Avenue Geneva, AL 36340 Initials_____

<b>For Staff Use Only:</b> Reviewed By/Date: _____ Facility: _____ Interview Date: _____
Financial Aid Referral: _____ Career Center Referral: _____ OJT Start Date: _____



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Voluntary Disability Disclosure

OMB No. 1205-0223 Expiration Date: 06/30/2024

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Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

Your name: \_\_\_\_\_

Date: \_\_\_\_\_

### **Why are you being asked to complete this form?**

Because we are a sponsor of a registered apprenticeship program and participate in the National Registered Apprenticeship System that is regulated by the U.S. Department of Labor, we must reach out to, enroll, and provide equal opportunity in apprenticeship to qualified people with disabilities.<sup>[1]</sup> To help us learn how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for apprenticeship, any answer you give will be kept private and will not be used against you in any way.

If you already are an apprentice within our registered apprenticeship program, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our apprentices at the time of enrollment, and then remind them yearly, that they may update their information. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

### **How do I know if I have a disability?**

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. Disabilities include, but are not limited to: blindness, deafness, cancer, diabetes, epilepsy, autism, cerebral palsy, HIV/AIDS, schizophrenia, muscular dystrophy, bipolar disorder, major depression, multiple sclerosis (MS), missing limbs or partially missing limbs, post-traumatic stress disorder (PTSD), obsessive compulsive disorder, impairments requiring the use of a wheelchair, and intellectual disability (previously called mental retardation).

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<sup>[1]</sup> Part 30 – Equal Employment Opportunity in Apprenticeship. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Apprenticeship website at <https://www.apprenticeship.gov/eo>.



**PART A: APPRENTICE'S INFORMATION**

1. First Name	Last Name	Answer Both 4a. and 4b. below  4. a. Ethnicity (Select One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Participant Did Not Self-Identify  b. Race (Select One or More) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Participant Did Not Self-Identify	5. Veteran Status (Select All That Apply)  <input type="checkbox"/> Non Veteran <input type="checkbox"/> Veteran <input type="checkbox"/> Non Veteran, Other Eligible Individual <input type="checkbox"/> Veteran, Eligible <input type="checkbox"/> Participant Did Not Self-Identify
Middle Name (Optional)	Suffix (Optional)		6. Education Level (Select One)  <input type="checkbox"/> Not High School graduate <input type="checkbox"/> High School graduate (including equivalency) <input type="checkbox"/> Some College or Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate or professional degree
Address (No., Street, City, State, Zip Code)	E-mail Address (Optional)		
Telephone Number (Optional)	*Social Security Number  - - -		
2. Date of Birth (Mo., Day, Yr.)	3. Sex (Select One)  <input type="checkbox"/> Male <input type="checkbox"/> Female  <input type="checkbox"/> Participant Did Not Self-Identify		
7. Employment Status of Apprentice (Select One)  <input type="checkbox"/> New Employee <input type="checkbox"/> Current Employee			
8. Did the apprentice complete a pre-apprenticeship program prior to their registration in this apprenticeship program?  <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, please provide the Pre-Apprenticeship Program Name and Address:			

**PART B: PROGRAM SPONSOR'S INFORMATION**

1. Program Number	2. Occupation (The work processes listed in the standards are part of this agreement.)
Sponsor's Name and Address (No., Street, City, State, Zip Code, County)	a. RAPIDS Code:
Telephone Number	b. O*NET Code:
Cell Phone Number (Optional)	c. Interim Credentials Offered (i.e., Career Lattice Occupation)?  <input type="checkbox"/> Yes <input type="checkbox"/> No
E-mail Address	