

APPLICATION 2026 – 2027

215 Fitchburg Street, Room B235
Marlborough, MA 01752
(508) 485-9430 ext. 2881

Ernest F. Houle, Superintendent-Director
Tina Martinez, MSN, RN, Dir. of Practical Nursing
Chuck DuPont, Financial Aid Advisor

ADMISSION DOCUMENTS / REQUIREMENTS

1. NLN-NEX admission test is required for all applicants. Verbal, Math, and Science sections must be taken. Minimum required scores are Verbal 58%, Math 45%. There is no minimum score for the Science section but admission points are awarded for all three (3) sections. NLN-NEX scores are acceptable for up to two (2) years prior to the student's start date in the program. The exam can only be taken 2 time during an admission cycle.
2. Complete and submit this application, including the Student Essays and your resume.
3. Provide three (3) professional references. At least one must be from a current or past employer. References from family members are not acceptable and from friends are discouraged. Suggested references include: employers, co-workers, teachers, or guidance counselors.
4. Be at least 17 ^{1/2} years of age, and provide a valid birth certificate or passport.
5. Maintain current certification in **Basic Life Support (BLS) for Healthcare Providers with AED** throughout the program through the *American Heart Association* or *American Red Cross* ONLY (hands on testing is mandatory).
6. Have the source mail your Original/Official U.S. High School transcript accredited by that State's Board of Education, or U.S. GED/HiSET **and** all Post Graduate/College Transcripts (if applicable). Students who do not possess a U.S. High School transcript or U.S. GED/HiSET can:
 - Test for a U.S. GED/HiSET in their city of residence, **or** Contact the Center of Educational Documentation Inc., P.O. Box 199, Boston, MA, 02117, 1-617-338-7171, www.cedevaluations.com for information on having foreign diploma/transcripts evaluated.
7. Interview with a faculty member of the Practical Nursing Program.
8. Maintain personal health insurance coverage throughout the program and provide a copy of your health insurance card.
9. Maintain Professional Liability Insurance Coverage throughout the program (provide copy of the certificate).
10. Meet the "Good Moral Character Requirements" defined by the Massachusetts Board of Registration in Nursing*.
11. Be subject to a CORI and SORI, Nurse Aid Registry check and Social Security Verification.
12. Meet health requirements of the Program.
13. Provide clear color copy of driver's license.

*Applicants must understand that a conviction or guilty plea in a court of law may prohibit or delay eligibility to take the NCLEX-PN Exam.

Preference is given to qualified in-district candidates who apply before March 1st of the application cycle. In-district includes residents of: Berlin, Hudson, Marlborough, Maynard, Northborough, Southborough, and Westborough.

Application information will be kept confidential and only released to members of the Assabet-PNP Admissions Committee and the Financial Aid Department, if applicable.

APPLICATION FOR ADMISSION

2026 – 2027

Please complete ALL sections of this application and submit to:

Assabet Practical Nursing Program
215 Fitchburg Street, Room B235
Marlborough, MA 01752

(Review page 1 for requirements)

Name: _____
(LEGAL Last Name) (First Name) (Middle Name)

Other last name under which records may appear (maiden, etc.): _____

Address / Apartment #: _____

City, State, Zip: _____

Cell Phone #: _____

Personal E-Mail Address: _____

Date of Birth: ____/____/____ Current Age: _____

Do you have a Social Security Number? Yes No (Do not write SS# on this application)

Citizenship: U.S. Foreign born, permanent U.S. resident Other _____
(Explain)

Name of Your Health Insurance Company: _____

BLS Certified? Yes No Expiration Date: ____/____/____ (Enclose a copy if expires after June 30, 2027)

Are you a CNA? Yes No (If YES, please provide a copy of the certificate including number and expiration date)

EDUCATION: Have OFFICIAL transcript(s) mailed directly to Assabet-PNP at the address above.

High School Name: _____ Date Graduated: ____/____/____
(Required)

GED/HiSET (Where obtained): _____ Date of GED/HiSET: ____/____/____

College(s) Attended or Graduated: _____

The Admissions Committee reserves the right to conditionally accept a student. Students accepted conditionally must meet all the conditions prior to the start of the program. All applicants will be notified in writing of the Admissions Committee's decision.

STUDENT ESSAY: *In 500 words or less, please send a typed essay with this application and tell us:*

1. Why have **you** chosen to pursue a career as a Licensed Practical Nurse?
2. At the completion of this program, what is **your** plan for the future?

The essay must be typed. Please do not handwrite or use AI.

REFERENCES: Please print clearly the names, addresses, and phone numbers of three (3) persons who will provide a reference for you. One must be a current or past employer; none may be family members. Suggested references include: employers/supervisors, teachers, guidance counselors or co-workers. References from friends are discouraged.

The applicant must provide each person listed below with a copy of the Reference Form on which you have **written your name and signed the waiver release statement**. Have them return the reference directly to: Assabet Practical Nursing Program, 215 Fitchburg Street, Room B235, Marlborough, MA, 01752.

1. Name: _____

Address: _____

_____ Phone: _____

2. Name: _____

Address: _____

_____ Phone: _____

3. Name: _____

Address: _____

_____ Phone: _____

To the best of my knowledge, I have completed this application accurately and truthfully. All documentation submitted is subject to verification by the Assabet-PNP Director.

Signature of Applicant

_____/_____/_____
Date

Class of 2026 - 2027

ADMISSION REFERENCE FORM (Must provide 3 references)

_____ has applied for admission to the Assabet Practical Nursing Program. He/she
Applicants Name
 has indicated that you are willing to provide a reference. Please assist the Admissions Committee with their decision making by completing the following information. Upon completion, please mail to: Assabet Practical Nursing Program, 215 Fitchburg Street, Room B235, Marlborough, MA, 01752.

Applicant will sign here if he/she will not request access to the reference form after the person providing the reference completes it.

I waive all rights to review this form.

 (Applicants Signature) _____
 (Date)

Please complete all sections below.

1. How long have you known this applicant? _____
2. In what capacity are/were you familiar with this applicant? (Check One)
 Employer Supervisor Co-Worker Teacher Counselor

	<i>SA= Strongly Agree</i>	<i>A= Agree</i>	<i>D=Disagree</i>	<i>SD= Strongly Disagree</i>
The applicant:	SA	A	D	SD
Works well with others				
Communicates well with others				
Is dependable				
Is prompt				
Is self-directed				
Is trustworthy				
Dresses appropriately, is neat and clean				

Name: _____ Position: _____

Place of Business: _____

Phone Number: _____

 Signature _____
 Date

ASSABET-PNP

PROOF OF IN-DISTRICT RESIDENCY (For In-District Applicant's Only)

A candidate qualifying for In-District tuition must provide documentation to prove physical residency in Berlin, Hudson, Maynard, Marlborough, Northborough, Southborough, or Westborough, PRIOR to January 1, 2027.

The document must be an **ORIGINAL, dated December 2026** with your name and physical address in one of the afore mentioned towns to qualify. If requested, the ORIGINAL document will be returned to you.

1. I (print applicants name) _____ understand that I must be a resident of Berlin, Hudson, Maynard, Marlborough, Northborough, Southborough, or Westborough PRIOR to January 1, 2027.

2. I certify that my physical residency is:

(street, apt #)

(city, state, zip code)

3. (Choose One and Attached **Original Document**)

I certify that I am a legal resident of _____. I have provided one (1) original document, displaying my name and physical address, selected from the approved documentation list below:

- Current 2026 property tax invoice
- December 2026 electric, gas, or oil bill
 - For utility bills, the document must include the service address and the connection date

I hereby certify under the pains and penalties of perjury the information provided above is accurate and true.

Applicant Signature

Date

TUITION 2026 – 2027*

*Subject to Assabet School Committee approval and State Revisions.

IN-DISTRICT TUITION: \$11,820*

OUT OF DISTRICT TUITION: \$18,158*

TUITION PAYMENT PLAN OPTIONS 2026 – 2027

(Payment terms subject to change by the Business Office of Assabet.)

Plan A

	<u>In District</u>	<u>Out of District</u>
Full payment by August 1 st	<u>\$11,820.00</u>	<u>\$18,158.00</u>

Plan B

	<u>In District</u>	<u>Out of District</u>
Due by August 1 st	\$5,910.00	\$9,079.00
Due by January 15 th	<u>\$5,910.00</u>	<u>\$9,079.00</u>
Total Tuition	<u>\$11,820.00</u>	<u>\$18,158.00</u>

Plan C

	<u>In District</u>	<u>Out of District</u>
Due by August 1 st	\$5,910.00	\$9,079.00
Due by October 1 st	\$844.00	\$1,297.00
Due by November 1 st	\$844.00	\$1,297.00
Due by December 1 st	\$844.00	\$1,297.00
Due by January 1 st	\$844.00	\$1,297.00
Due by February 1 st	\$844.00	\$1,297.00
Due by March 1 st	\$844.00	\$1,297.00
Due by April 1 st	\$846.00	\$1,297.00
Total Tuition	<u>\$11,820.00</u>	<u>\$18,158.00</u>

NOTE: Students receiving federal financial aid will receive an individual tuition payment invoice for the balance of their payments based upon the payment plan chosen.

Tuition payments may be made by official bank check or money order made payable to AVRTS, or by credit card on-line at assabetaface.org: [Practical Nursing Program](#) (tuition page).

For information regarding tuition reimbursement from withdrawal from the program, please refer to the Assabet-PNP *Student Handbook/Catalog* on our website.

IT WILL BE YOUR RESPONSIBILITY TO CONFIRM ALL DOCUMENTATION HAS BEEN RECEIVED.

ESTIMATED PNP STUDENT EXPENSES

*The 2026 – 2027 rates are not available at this time.

The following **estimated** expenses are the responsibility of the student and any such other expenses as may be necessary for completion of the program.

Textbooks	\$625
Entrance Exam	\$86
Virtual Clinical Tools	\$100
Uniforms (3 sets)	\$200
Liability Insurance	\$45
Grad. Expense/Class Dues	\$100
ATI Online Testing Package	\$1,410
Sphygmomanometer	\$25
Pen Light	\$5
Bandage Scissors	\$7
Kelly Clamp	\$7
Stethoscope	\$65
Drug Screening	\$60
ESTIMATED TOTAL:	\$2,719

Note:

Students must have their own laptop computer for class.
Pens and pencils, loose-leaf notebooks, white shoes/
stockings and a wristwatch with a second hand will be
necessary expenses incurred by the student.

STUDENT FEES

Registration Fee	\$500	Due on acceptance into the program. Fee is nonrefundable.
Lab Fee	\$350	Due by August 15, 2026. Fee is nonrefundable.
TOTAL:	\$850.00	

STEPS FOR FEDERAL STUDENT FINANCIAL AID FOR SEPTEMBER 2025

1. Complete and submit your 2025 Federal Income Tax Return.
2. Complete the *Free Application for Federal Student Aid* for the 2026-2027 school year at www.fafsa.ed.gov. Please follow all instructions very carefully.
3. Order your official Tax Return Transcript for 2025 at www.irs.gov.
4. After you have completed your FAFSA, received your Tax Return Transcript, **and** you have been accepted into the PN Program, email the Financial Aid Department at pnfa@assabet.org to set up a financial aid appointment.

LENGTH OF PROGRAM

August 2026 through June 2027

PROGRAMS HOURS

Monday through Friday 7:50 a.m. - 2:20 p.m.

The Practical Nursing Admissions Committee reviews applications at meetings throughout the year. Qualified candidates may be offered **early acceptance**. Applicants completing the process late in the year are considered on a space availability basis.

The LPN must successfully complete an educational program that provides the knowledge, skills and attitudes to practice and to pass the national licensing examination, NCLEX-PN. The Assabet program (Assabet – PNP) is designed to prepare graduates to take the NCLEX-PN exam and be employed in a variety of nursing settings.

Clinical practice is a strong component of this program. Practice is planned in acute care, sub-acute care units, rehab hospitals, doctor's offices, and long-term care facilities. Students will rotate through all assigned agencies and are required to provide their own transportation.

The nursing program has Approval with Warning Status from the Massachusetts Board of Registration in Nursing. The nursing program is accredited by the Accreditation Commission for Education in Nursing Inc. (ACEN), 3390 Peachtree Road NE, Suite 1400, Atlanta, Georgia, 30326, (404) 975-5000, www.acenursing.org. The school is accredited by the New England Association of Schools and Colleges (NEASC), Commission on Public Schools Committee on Technical and Career Institutions.

This school is in compliance with Federal Regulations, Title II, Title VI, Title IX, and Section 504 and the Commonwealth of Massachusetts regulations under Chapter 622 of the Acts of 1972, and makes available its advantages, privileges, and courses of study without regard to race, color, sex, religion, national origin, sexual orientation, handicap or disability.

SPECIAL ACCOMMODATIONS

In order for the Assabet – PNP to investigate, review and evaluate all special accommodations, the request for special accommodations and necessary documentation must be submitted thirty (30) days prior to the requested entrance examination date. Individuals with a qualified disability seeking a reasonable accommodation will be notified by email of the test accommodation prior to the examination date.

The Assabet – PNP seeks to provide reasonable accommodations for all qualified individuals with a disability. The Assabet – PNP will adhere to all federal, state, and local laws, regulations and guidelines with respect to providing reasonable accommodation as required affording equal education opportunity. It is the applicant's responsibility to request a reasonable accommodation for their disability including necessary documentation when they accept admission.

ASSABET - PNP

Health Clearance Form

After you have been **accepted** into the program, completed documents are due by **August 15th**.

PN Student Name: _____

Date of Birth: ____ \ ____ \ ____

For the protection of students, patients, faculty and other personnel, individuals accepted to the Practical Nursing (PN) Program must provide documented proof of specific immunizations and/or immunity as appropriate, as well as completing a comprehensive screening for substances of potential impairment or abuse. Certain clinical agencies have immunization requirements that exceed those of the MA Department of Public Health and as a result the Program cannot make any exceptions. Failure to provide all required documentation may exclude the PN student from clinical practice and participation in the Program.

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER

This is to verify that _____, was examined by me on ____ \ ____ \ ____.

Summary of Findings (check one):

- Well student; no conditions identified that would limit the ability to participate in the PN Program and safely perform nursing activities.
- Conditions have been identified that would limit the ability to participate in the PN Program and perform nursing activities.

The identified condition(s) does not pose a risk to safe nursing practice. (Please identify condition, limitations, rationale for, and duration of the specific limitations.)

By signing below, I find her/him to be free of any health impairment which is of potential risk to students, patients, faculty, and other personnel and which might interfere with the safe performance of her\his nursing student responsibilities, with or without reasonable accommodation. Habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances that may alter the individual's behavior has been considered in this evaluation.

Signature* of Examining Healthcare Provider: _____ Date: ____ \ ____ \ ____

(*Stamp is NOT ACCEPTABLE in place of signature)

Business stamp, copy of letterhead, or business card may be used for the following required information:

Print Name: _____

Office or Agency Name: _____

Address: _____

Telephone Number: _____

STUDENT: Please retain a copy of this document for your records.

ASSABET - PNP

Verification of Immunization Form

Print Student Name: _____

Date: ____/____/____

All students are *conditionally* accepted to the Program until all immunity requirements are met, prior to the first day of clinical, or acceptance into the program will be withdrawn.

Directions: Provide the dates of the following immunizations or Titer results. Please – **do not** attached documents. Your Health Care Provider (HCP) must complete and sign this form.

<u>Disease</u>	<u>Immunity Requirements</u>		<u>Titer Results</u>
Influenza (Flu)	1 dose as soon as available	>	Flu Vaccine Date: ____/____/____
TDAP (Tetanus, Diphtheria, Pertussis)	1 does of TDAP vaccine within 10 years	>	TDAP Vaccine Date: ____/____/____
MMR (Measles, Mumps, Rubella) – Requires 2 doses of vaccines OR 3 positive titers	Dose #1 Date: ____/____/____ Dose #2 Date: ____/____/____	OR	Measles Positive Titer: _____ Mumps Positive Titer: _____ Rubella Positive Titer: _____
Varicella Requires 2 vaccines OR 1 positive titer	Vaccine #1 Date: ____/____/____ Vaccine #2 Date: ____/____/____	OR	Varicella Positive Titer: _____
Hepatitis B	Positive Titer Date: ____/____/____ * NEGATIVE Titer results requires <i>Hepatitis B Acknowledgement Form</i>	OR	*Complete for NEGATIVE Titer only Hepatitis B Acknowledgement Form Signed: ____/____/____
Meningococcal	1 dose for any health science student age of 21 or younger	>	Meningococcal Vaccine Date: ____/____/____

Tuberculosis Select only 1 screening method (TST OR IGA OR CXR) and provide required results and date	1 NEGATIVE TB Skin Test (TST) within 1 year	>	TST Date: ____/____/____ Result: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE
	1 NEGATIVE IGA (t-spot OR QuantiFERON) within 1 year	>	IGA Date: ____/____/____ Result: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE Test: <input type="checkbox"/> t-spot <input type="checkbox"/> QuantiFERON
	<input type="checkbox"/> History of Positive TB	>	NEGATIVE Chest X-Ray: ____/____/____ (within past 2 years) OR Completed only for history of POSITIVE TB TB Screening Form Date: ____/____/____
COVID-19 Need proof showing all COVID vaccinations and boosters.	2 Doses Moderna or Pfizer OR 1 Dose Johnson & Johnson AND Most up-to-date COVID-19 vaccination.	AND	<input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer Dose #1 Date: ____/____/____ Dose #2 Date: ____/____/____ OR <input type="checkbox"/> Johnson & Johnson Dose #1 Date: ____/____/____ AND Manufacturer: <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer Date: ____/____/____

Signature* of Examining HPC: _____ **Date:** ____/____/____
 (*Stamp is NOT ACCEPTABLE in place of signature)

Print HCP Name: _____

Office or Agency Name: _____

Address: _____

Telephone Number: _____

The signature below confirms these immunization documents have been provided to the Assabet PN Program and are verified to be complete and accurate.

 ASSABET - PNP Director MSN, RN

Date: ____/____/____