Practical Nursing Application
Packet 2026-2027 School Year

The Practical Nursing Program at Radford M. Locklin Technical College (Locklin Tech) is very competitive. Applicants must complete the application to Locklin Tech and the Practical Nursing Application Packet within the due dates to be eligible for consideration to the program. This page serves as a checklist to ensure completion of all steps prior to the deadline. Complete instructions for each task are enclosed in the packet. Read each item carefully and follow the instructions. Student Services is located in Building 1 on the college campus. Call 850-983-5700 X 3454 for more information.

All required documents are due in Student Services before 3:30 PM on June 19, 2026.

Applicants considered for registration will be notified via email of admission status after June 26, 2026.

Required Tasks	Fee Required	Check When completed
Apply to Locklin Tech in Student Services	No	
Send official transcript(s) to Locklin Tech	Varies per institution	
Pay for & schedule Kaplan Nursing Admissions Test	$50 per test	
Pay for & schedule Post-Secondary Readiness Test (PSR)	$20 per test	
Enroll in PSR Remediation if needed	$30	
Read & Sign Cost and Fee Sheet	No	
Read & Sign the Training Site Affiliation Agreement	No	
Read & Sign the Attendance Policy	No	
Read & Sign Medical Information Agreement	No	
Proof of Current Immunizations or Titer	Varies	
Complete Pre-participation Physical Evaluation Form (2 pages)	Varies	
Read & Sign Health Insurance Requirement	No	
Read & Sign 10 - Panel Rapid Drug Test Policy	No	
Complete 10 – Panel Rapid Drug Screen	$45	
Complete & Sign Self-Disclosure Form	No	
Complete Form A – VECHS Waiver	No	
Complete Level 2 Background Screening and Fingerprinting	$100 / approximately	

All applicants must meet all health and vaccination requirements outlined in the packet and in the clinical training facility affiliation agreements prior to enrollment or participation in clinicals.

All high school and/or college transcripts must be mailed or sent electronically to the attention of "Student Services". Transcripts must have the official seal from the issuing institution. The cumulative GPA should be 2.0 or higher for admission to the program.

Mailing Address: Radford M. Locklin Technical College
5330 Berryhill Road
Milton, Florida 32570
ATTN: Student Services

Email Address: Simmonscl@santarosa.k12.fl.us

The **Kaplan Nursing Admissions Test** (Kaplan) is required to determine if students have the academic skills necessary to perform effectively in the Practical Nursing Program. This admission test is online with 91 multiple choice questions that evaluate basic reading, math, writing, and science skills.
Kaplan requires a personal account for testing. After scheduling the Kaplan Nursing Admissions Test, register online at https://www.kaptest.com/nclex/partner/locklin-technical-college . This must be completed prior to the scheduled exam.

The **post-secondary readiness (PSR)** is required as a part of the Practical Nursing Application. Additional post-secondary readiness testing may be required to meet the Florida State Board of Education Rule 6A-100.040 if you do not meet exemption requirements. For more information on PSR see the Locklin Tech Curriculum Guide and Student Handbook.

Schedule ALL testing through Student Services. All tests must be prepaid and scheduled in advance. Testing takes place in the Locklin Tech Testing Lab on campus.

No call or No show for any testing will eliminate you from the applicant pool.

See chart below for typical testing schedule:

Test	Monday	Tuesday	Wednesday	Thursday
Kaplan	9:30 AM	N/A	12:30 PM	N/A
PSR	N/A	9:30 AM	N/A	12:30 PM

Applicants may retest for a higher score. The cost of a retest is the same as the cost of the first test. There may not be time to schedule a retest if the initial test is taken after April 24, 2026.

The Kaplan Nursing Admissions Test may only be taken two times per year.

Program information:

Once accepted, there is a mandatory orientation on July 14, 2026 at 10:00 AM or July 16, 2026 at 1:00 PM. Students will sign up at time of registration.

Program begins August 10, 2026, and ends in July 2027. This is two semesters plus an eight-week summer term. Students must be in attendance every day. The program is fast-paced and intense. Absences will lead to poor progress and possible removal from the program.

Class hours and dates are approximate for the 2026-2027 school year. Classes meet Monday through Friday from 8:30 am to 3:15 pm. Class hours will vary during clinical rotations.

Drug screening(s) may be completed randomly throughout the program at your expense. Any 'positive' results may dismiss you from the program immediately.

If admitted, tuition and fees for each semester are due two weeks prior to the first day of the semester. Contact Student Services for more information on financial aid.

Returning to the Practical Nursing program requires minimum scores on the Kaplan Nursing Admissions Test. Information is available upon request.

Applicants are encouraged to prepare for the Kaplan Nursing Admissions Test. There is a prep book available through Amazon and at local bookstores. The current exam prep book is: "Kaplan Nursing School Entrance Exams Prep 10th Edition." This textbook is for all nursing entrance exams and includes more in-depth information than required on this specific Admissions Test. Kaplan recommends that applicants study the areas listed in the "Outline of the Admissions Test".

Outline of Kaplan Nursing Admissions Test:

i. Reading Comprehension
    a. 45-minute test with 22 questions
    b. Four passages and questions.
        i. Determine the logic of a passage
        ii. Comprehend details
        iii. Drawing basic inferences
        iv. Identifying the purpose of a passage

ii. Math
    a. 45-minute test with 28 questions
    b. Measures ability to apply mathematical principles.
        i. Conversions
        ii. Operations
        iii. Ratios
        iv. Word problems

iii. Writing
    a. 45-minute test with 21 questions
    b. Nine passages and questions that measure essential skills required for writing.
        i. Assessing passage development
        ii. Assessing paragraph logic
        iii. Assessing mechanics of writing

iv. Science
    a. 30-minute test with 20 questions
    b. Measures knowledge of physiology.
        i. Cardiovascular system
        ii. Electrolytes
        iii. Gastrointestinal system
        iv. Immune system
        v. Neurology
        vi. Renal system
        vii. Hematological system
        viii. Homeostasis
        ix. Respiratory system
        x. Sensory system

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Cost and Fee Sheet

2026-27 School Year

The following chart includes the approximate costs if admitted into the Practical Nursing Program. These are subject to change without notice. Items listed are required to complete the Practical Nursing Program.

Required Registration Fee	$70 ($35 per registration)
Tuition*	$4250 (2 semesters + summer term)
Curriculum	$1300
TABE/PSR	$20
Parking Decal	$10
Drug Screening - Random	$45
Uniforms/Supplies	$350
TB Screening/Flu Shot	$270 (before clinical rotation)
Immunizations, if applicable	MMR: $200 - Tetanus: $45 - Hepatitis B: $350
NCLEX-PN (Licensure Exam and fees)	$400 (at end of the program)
CPR Certification	$100

* Tuition is paid by semester NOT in full at the beginning of the program. Tuition and fees are for the 2026-2027 school year and include the cost of technology, scholarships, capital improvement, and lab fees. If admitted, students may complete the Free Application for Federal Student Aid (FAFSA). All students are encouraged to apply. Applicants may discuss financial aid with the Financial Aid Counselor in Student Services.

Note: Enrollment in and completion of a healthcare program is not a guarantee of obtaining Florida Department of Health licensure as a Licensed Practical Nurse or Certified Nursing Assistant. It is understood by the applicant that program performance, state testing, and other criteria, including, but not limited to, those disqualifying offenses listed in SS. 435.04, FLA STAT. may prevent or limit the applicant's ability to participate in the required training or meet other requirements for such state licensure.

I understand that I am responsible for ALL expenses for this program not covered by financial aid, scholarships, or other funding sources. Financial aid may cover tuition and fees, books, exams, and uniforms/scrubs.

Print Name _____ Date _____
First Name Middle Name Last Name

Applicant Signature _____ Date _____

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Training Site Affiliation Agreement Compliance

In addition to being held accountable to all applicable rules and policies set forth in the Santa Rosa County District Schools (SRCSD) Code of Conduct, the Locklin Technical College Curriculum Guide and Student Handbook and the Nursing Program policies, all program participants are required to meet and maintain compliance with all standards of the current affiliation agreements between the Santa Rosa County School Board and the clinical training site as outlined under the educational institution agreement section.

All student worksite internships and clinical rotations for Nursing Programs will operate under the policies of Locklin Technical College, approved affiliation agreements between the worksite and the SRCSD, program of study specific policies, and applicable program related licensing board and accreditation rules and regulations.

In addition, the affiliation agreements afford the worksite the right to deny a student application for placement or continued participation at any time if they determine the applicant or student is a risk to the patient, the facility, or is in the best interest of the worksite. In such instances, the facility or worksite must provide the school with written notice of any decision to deny access or remove a student from an internship or clinical rotation. After receiving written notification, the college will review and determine whether continued student participation in the internship program or clinical rotation is possible. Worksite or clinical rotation alternative placement will be considered if appropriate and available. In instances where completion of a program of study requires an internship or clinical hours and alternate placement is not appropriate or available, the Student Intervention Team (SIT) process will be utilized to review and render a recommendation to the administration related to continued student program enrollment or removal of the student from the program.

For all Nursing Programs, the affiliated worksite under Florida Statute Chapter 435.07(3); is required and retains the right to review and approve all program applications including background checks for both potential applicants and current program students requesting permission to work under their operational license with the Board of Nursing to ensure compliance with all regulations and standards of care set forth by the Board of Nursing.

All communication related to student internship and clinical hours must be addressed to student services. At no time will the student be allowed to address any concerns or grievances directly to the worksite. Any attempt to address the worksite, the facility or its agents directly will result in immediate removal from the worksite. Student grievances related to internship and clinical hours for the Nursing Program will follow the policies and procedures outlined under Complaints and Grievance Procedures for postsecondary students in the Locklin Technical College Curriculum Guide and Student Handbook.

Students can be denied access to the clinical training site at any time by the nursing program instructor or facility director for any acts of noncompliance with the training site affiliation agreements, school policy violations, or specific program policies.

I understand that I am responsible for understanding and adhering to the Practical Nursing Program's Training Site Affiliation Agreement Compliance Document. It is the applicant's/student's responsibility to request copies of any documents mentioned in this agreement.

Print Name _____ Date _____

Applicant Signature _____ Date _____

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Practical Nursing Program Attendance Policy

Research indicates a high correlation between attendance, punctuality, and job success. Business and industry can function only when their employees are working; the same is true for instructional programs. Locklin Technical College strives to teach high standards for job prep and employability skills. Students who have excessive absences miss classroom experiences that cannot be recaptured. Students are expected to be in class on a regular basis, be on time, and remain there unless excused or dismissed by the instructor. Student success in the program is contingent upon meeting program hours and competency requirements. **Excessive absences, tardiness, leaving early, or not making adequate progress in a program may result in an administrative withdrawal.** The purpose of this policy is to promote an efficient learning atmosphere and to prepare students for the highly demanding health career field.

The Practical Nursing Program at Locklin Technical College has a very stringent attendance policy. Students who violate this policy will be administratively withdrawn. Be sure you can commit to this program's policies before enrolling.

Six absences are considered excessive whether they are excused or unexcused. It is your responsibility to understand the program's attendance policy.

- Administratively withdrawn upon accrual of the 8th absence.
- Three missed clinical days will result in an administrative withdrawal.

I understand that I am responsible for understanding and adhering to the Practical Nursing Program's Attendance Policy.

Print Name _____ Date _____

Applicant Signature _____ Date _____

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Medical Information Agreement

I, the undersigned, recognize and understand the risks of sickness and physical injury inherent in the nursing program. I fully assume those risks. I further recognize and understand that such inherent risks may increase in case of pregnancy, and if pregnant, I fully assume those risks on behalf of myself and my unborn child. I hereby release the Santa Rosa County School Board (SRCSB) and R. M. Locklin Technical College, (Locklin Technical College) the owners of any Clinical Affiliation to which I may be assigned while participating in the nursing program, and their officers, agents, and employees from all liability for injuries sustained or illnesses contracted by me or any unborn child while attending or participating in my chosen nursing program. I agree to indemnify, defend, and hold harmless Locklin Technical College, the Clinical Site, and their officers, agents, and employees for all liabilities, costs, and judgments arising from acts or omissions committed by me which could result in injury or damage to any person or property.

If I become pregnant during the program, or if I am temporarily physically or mentally impaired due to an accident or illness, I agree to obtain a medical release from my physician stating that I am able to perform my duties as outlined in the program standards. The medical release will pertain to participation in the program's classes and labs as well as to potential physical interaction with patients and staff in a clinical setting. I recognize that not all health status changes remain uncomplicated and that I may not be able to complete my studies. Please refer to the Locklin Technical College Curriculum Guide and Student Handbook and the Practical Nursing Attendance Policies.

I agree to abide by any rules, regulations, and policies set forth by the SRCSB and Locklin Technical College.

In case of physical injury or medical emergency, I hereby authorize SRCSB and Locklin Technical College to make necessary arrangements to transport me to a medical treatment facility as necessary. All such transportation and medical treatment will be at my sole cost and expense. In an extreme emergency, I understand that the SRCSB and Locklin Technical College will attempt to notify the person(s) I have named on my Health Card as my emergency contact(s) of my condition and how to reach me.

A student who has a serious injury, illness, or surgery while enrolled in the program will furnish the college with a **Change in Medical Status** form signed by their physician stating that they are permitted to perform the duties outlined in the program's standards, including physical interaction with potential patients and staff in a field or clinical setting.

All sections on both sides of the **Pre-participation Physical Evaluation** form must be completed. Pay close attention to the sections that must be completed by a MD, DO, ARNP, or PA. Prior to your physical appointment, applicants should complete the student portion of the form (side one) and obtain your immunizations records. Take immunization records and a list of current medications to your physical appointment. Plan ahead. The Pre-Participation Physical Evaluation Form is not a medical emergency and appointments may be limited. Once submitted, this form belongs to Locklin Technical College. Please make a copy for your records before submitting them to the college.

Print Name _____ Date _____

Applicant Signature _____ Date _____

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Health Insurance Requirement

The Training Site Affiliation Agreements may require students to have active health insurance while participating in clinicals rotations at their site.

A. Documentation demonstrating coverage must be provided showing that each nursing student has active health insurance for the duration of their clinical rotation.

B. Nursing students must show proof of active health insurance while enrolled in the Practical Nursing Program.

Acceptable Proof of Health Insurance

- A copy of the insurance card (front and back) showing the student's name and policy/group number.
- An insurance company-issued verification letter or coverage summary that includes the student's name, policy number, effective dates, and coverage status.
- A current declaration page (binder) from the insurance policy listing the student as the insured.
- An employer benefits verification letter or paystub reference indicating active coverage (if employer-sponsored).
- A government-issued benefits letter (e.g., Medicaid/Medicare) showing the student's name and active enrollment dates.

I understand that I may be required to show proof of health insurance prior to participating in clinical rotations.

Print Name _____ Date _____

Applicant Signature _____ Date _____

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10-Panel Rapid Drug Test Policy

A drug screening will be completed as part of the application and randomly throughout the program. Any 'positive' results will be reviewed to ensure compliance with both the Board of Nursing Licensing requirements and all clinical site Affiliation Agreements.

In addition, Locklin Technical College will conduct random 10- panel drug screenings for students enrolled in the nursing programs to ensure continued compliance. Screenings will be completed after the school year begins and before/during clinicals. This is required for ALL applicants/students. Any positive results from the drug screening will be reviewed by the Director of Nursing followed by a recommendation to administration for withdrawal or continued program enrollment.

The drug test screens for the following drugs:

- Amphetamines
- Barbiturates
- Benzodiazepine
- Cocaine
- Marijuana
- Methadone
- Methamphetamines
- Opiates /Morphine
- Phencyclidine
- Tricyclic Antidepressants

I understand that I am required to have a 10-panel drug screening at time of application and random 10 panel drug screening(s) at a cost to me throughout the program. Note: the 10-panel drug screening is not covered by Financial Aid.

Print Name _____ Date _____

Applicant Signature _____ Date _____

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Immunization Guidelines

Measles (Rubeola): one of the following
- Positive antibody titer, (blood test to prove immunity to the disease)
- Official documentation of immunization with two (2) doses

Mumps: one of the following
- Positive antibody titer, (blood test to prove immunity to the disease)
- Official documentation of immunization

Rubella (German measles): one of the following
- Positive antibody titer, (blood test to prove immunity to the disease)
- Official documentation of immunization

Varicella (chickenpox): one of the following
- Positive antibody titer, (blood test to prove immunity to the disease)
- Official documentation of immunization

Tetanus/Diphtheria (TD) within 10 years

Hepatitis B: one of the following
- Positive antibody titer, (blood test to prove immunity to the disease)
- Official documentation of immunization
- Hepatitis B immunization is REQUIRED for participation in the clinical portion of the program. Please plan to complete this series by December 18, 2026.

Tuberculosis: PPD (Skin Test): good for one-year Applicants with positive TB test:
- Must be found free of active TB via baseline chest x-ray
- Subsequently, when a PPD is required, the individual must be certified as free of the signs and symptoms characteristic of active TB. The provider's signature indicates the individual with a positive TB test is free of these signs and symptoms.

Covid-19 Vaccination:
- Proof of vaccination or eligibility for exemption (if allowed) as outlined in the clinical training facilities affiliation agreements.
- Periodic negative Covid-19 testing may be substituted for vaccination at some of the clinical training facilities.

Seasonal Influenza*: annually
- Vaccination date appropriate for clinical placement. Please note, Flu vaccines must be current prior to clinicals and should be completed after school starts but before clinicals (August/Sept. 2026).

Other vaccinations may be required if there are changes in requirements from the Center for Disease Control and Prevention (CDC), Florida Board of Nursing (BON), or our affiliated facilities.

Immunization and Physical Pricing Information

This sheet is listed as a courtesy for the applicant. All prices listed below are approximate and subject to change without notice and are not covered by financial aid.

IMMUNIZATION	APPROXIMATE COST
Hepatitis B Vaccine (three separate vaccinations) **Or** **Hepatitis B Titer**	$113 each dose $66
TB screening (ppd)	$30
MMR Vaccine **Or** **MMR Titer**	$100 each dose $87
Varicella Vaccine (two separate vaccinations) **Or** **Varicella Titer**	$185 each dose $51
Tetanus/Diphtheria **Or** **Tdap (one or the other in the past 10 years)**	$43 $60
Flu Vaccine/shot to be completed after school starts but before clinicals (August /September)	$38
Covid 19 Vaccine (not required for program enrollment; however, may be required by clinical facility)	$191 (if no insurance)

Prohealth office locations: Vaccines and titers may be completed at any location. Physicals are only available at the Pro-Clinic and there is a $40 fee.

4942 Highway 98, Suite 23
Santa Rosa Beach, FL 32459
850-267-0360
M-F: 7:30 AM – 3:00 PM
Check-in by 12:00 PM

No physicals at this location

102 Alabama Street Suite B
Crestview, FL 32536
850-689-7592
M-F: 7:30 AM – 12:30 PM
Check in by 1:00 PM

No physicals at this location

224 Eglin Pkwy. NE
Fort Walton Beach, FL 32547
850-243-2900
M-F: 8:00 AM – 4:00 PM
M, W, F Physicals
Check in by 3:00 PM
appointments available or walk-in

5825 Highway 90
Milton, FL 32570
850-626-3430
M-F: 7:30 AM – 3:30 PM

4655 Woodbine Road
Milton, FL 32571
850-889-8890
M-TH 7:30 AM – 4:30 PM
F: 7:30 AM – 1:00 PM
appointments available or walk-in

1157 Gulf Breeze Pkwy.
Gulf Breeze, FL 32561
850-677-0737
M-F: 8:00AM – 4:00 PM

6005 College Parkway, Suite 2
Pensacola, FL 32504
850-549-3379
M-F: 8:00AM – 4:00 PM
SAT: 8:00 AM – 1:00 PM

Proof of Current Immunizations

Applicant Name _____ Date of Birth _____

Immunization Record: (refer to Immunization Guidelines for requirements). Do not leave anything blank. Applicant may use a different form or Health Department Records.

Disease/Pathogen	Date of immunization		Attach a copy of all titer results
Tetanus/Diphtheria	Date: DD/MM/YY		**N/A**
Measles	#1 DD/MM/YY	#2 DD/MM/YY	Titer Date:_____ Results: POS or NEG circle
Mumps	#1 DD/MM/YY	#2 DD/MM/YY	Titer Date:_____ Results: _____
Rubella	#1 DD/MM/YY	#2 DD/MM/YY	Titer Date:_____ Results: _____
Varicella	#1 DD/MM/YY	#2 DD/MM/YY	Titer Date:_____ Results: _____
Hepatitis B	1. DD/MM/YY 2. DD/MM/YY 3. DD/MM/YY		Titer Date:_____ Results: _____
Tuberculosis	PPD Date Given_____Date Read_____Results_____ Applicants with a positive TB test must provide a baseline chest x-ray.		

The information on this form is complete and correct to the best of my knowledge.

Name of Provider _____ MD DO ARNP PA (circle one)

Address _____Phone: _____

License Number: _____

Signature of Provider _____ Date _____

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PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part 1. Student Information: (to be completed by the applicant).			
Student Name:			
Grade: Adult	Gender:	Age:	Birthdate:
Home Address:	City	State	Zip
Primary Phone: ( )	Secondary Phone: ( )		
Personal Physician:			

If not applicable, please write "none" on the line.

Allergies	**Reaction/Treatment**
Medications	
Foods	
Latex	
Other	

Physical Identify any past or present health problems, including chronic illnesses (physical, mental, or emotional), infectious diseases, and current treatments. If a change in your medical status occurs complete the Change in Medical Status form.

	Current Treatment
Diabetes	
Seizure Disorder	
Cardiac Disorder	
Infectious	
Mental/Emotional	
Under physician care over the previous 12 months	
Surgery (over last 12 months)	
Other	

List Current Medications
Any changes to current medications must be in writing and reported to the instructor and documented on the student Health Card. You may attach a separate sheet of paper if needed.

I am aware of the abilities and skills requirements listed on the performance standards. To the best of my knowledge, I have the abilities and skills to participate in the identified program. I certify that all of the information provided by me is accurate and complete.

_____ _____

Signature Date

Part 2. Physical Examination (to be completed by physician).			
Student Name:	DOB:	Height:	Weight:
Pulse: Blood Pressure:	Visual Acuity: Right 20/	Left 20/	Corrected: Yes No

Findings	Normal	Abnormal
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Neck		
Back		
Arm/Shoulder/Wrist/Hand		
Hip/Thigh		
Leg/Ankle/Foot		

Healthcare Provider:

1. Is there any significant medical history or condition, including the presence of infectious disease that could affect functioning as a health care student which by its nature involves interaction with patients and staff in clinical settings?

Yes_____No_____Please Describe: _____

2. Is this individual currently taking any medications or undergoing any treatments that could affect participation in a health care education program, including interactions with patients and staff in clinical settings?

Yes_____No_____Please Describe: _____

3. I am aware of the Performance Standards for the identified health care program at Locklin Technical College and, after a complete examination; I certify that this individual can meet the performance standards.

Yes_____No_____Please Describe: _____

The information on both sides of this form is complete and correct to the best of my knowledge.

Name of Provider _____ MD DO ARNP PA (circle one)
Address _____Phone: _____
License Number: _____
Signature of Provider _____ Date _____

Part 3. Statement of Understanding
Locklin Technical College does not provide health insurance for students nor is Locklin Technical College or any clinical facility utilized by Locklin Technical College students responsible for student injury or accident.
Applicant Signature:

ProHealth

Company Name: Radford M. Locklin Technical College___ **Date:** _____

Donor Name: _____

Type of Test

✓ 10 Panel Rapid Instant

___ Other: _____

✓ **Donor will pay at the time of service**.

Authorized by: _____ Phone: _____

I give consent for ProHealth to email the results of my drug screen to Cathy Simmons. I understand that my results must be emailed to Locklin Technical College by the application deadline.

Donors Signature: _____ Date: _____

Office location:
No appointment is necessary for drug testing – please arrive no later than 30 minutes before closing for drug testing. Hours are subject to change due to emergency collections or illness.

The drug screening must be completed at the location listed below.

Milton (850) 626-3430
5825 Highway 90
Milton, FL 32583
Mon – Fri 8:00 a.m. – 2:00 p.m.
Office Manager: Stephanie Wilson

Collectors Signature: _____ **Date**: _____

Email results to Cathy Simmons at simmonscl@santarosa.k12.fl.us

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Self-Disclosure of Employment, Criminal, and Mental Health History

_____

Last Name First Name Middle Name/ Initial Date of Birth

_____

Maiden or other name(s) used in all other records of birth or records of residence.

_____

Street Address City State Zip

In connection with my application and desire to engage in clinical training at affiliated sites, I hereby consent and authorize **Locklin Technical College** (the College), at any time during or subsequent to my application process, to request a mental health history questionnaire and a background check that may include an employment and criminal record check and such additional verifications and reference checks as deemed necessary, and as required by the affiliation agreements with **the College** and the clinical sites. I do hereby consent to **the College's** use of any information provided on this form during the application process in performing the related background checks. I authorize the release of my criminal history records to other qualified entities as required by the affiliation agreements with clinical sites. I agree to release, indemnify, and hold harmless **the College** and any agency used by **the College** regarding any information provided. I will provide any additional information if requested. I acknowledge that facsimile, copy of electronic version of this form, shall be as valid as the original.

YES_____ **NO**_____ Have you EVER been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____ Date of Offense: _____
Details:_____
_____

YES_____ **NO**_____ Have you ever received deferred adjudication or similar disposition for any federal, state, or municipal offense?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____ Date of Offense: _____
Details:_____
_____

YES_____ **NO**_____ Have you ever received probation or community supervision for any federal, state, or municipal offense?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____ Date of Offense: _____
Details:_____
_____

YES_____ **NO**_____ Have you ever been convicted of any criminal offense in a country outside the jurisdiction of the United States?

If yes, please provide details below. Use additional paper if needed.
Country:_____Date of Offense: _____
Details:_____
_____

YES_____ **NO**_____ As of the date of the consent form, do you have any pending charges against you?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Charges: _____
Details:_____
_____

YES_____ **NO**_____ Have you ever had disciplinary action taken against your license to practice any health care-related profession by the licensing authority in Florida or in any other state, jurisdiction or country?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Action: _____
Details:_____
_____

YES _____ **NO** _____ Have you ever had any final disciplinary action taken against you by an institution such as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Action: _____
Details:_____
_____

YES _____ **NO** _____ Have you ever had any final disciplinary action taken against you by a national nursing specialty board that is recognized by any board of nursing?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Action: _____
Details:_____
_____

Applicant Name: _____

YES ☐ **NO** ☐ Within the previous ten years have you ever been allowed to or asked to resign from any facility instead of disciplinary action or during any pending investigation into your practice?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Resignation: _____
Details:_____
_____

YES ☐ **NO** ☐ In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for the treatment of drug or alcohol abuse that occurred within the past five years?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Enrollment: _____
Details:
_____
_____

YES ☐ **NO** ☐ In the last five years, have you been admitted or referred to a hospital, facility, or impaired practitioner program for the treatment of a diagnosed mental disorder or impairment?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Admittance: _____
Details:_____
_____

YES ☐ **NO** ☐ In the last five years, have you been voluntarily or involuntarily admitted to a facility for institutionalization or examination for mental health concerns, behaviors, or actions that are likely to inflict harm to self or others?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____Date of Admittance: _____
Details:_____
_____

YES ☐ **NO** ☐ Are you currently receiving Mental Health Services?

If yes, please provide details below. Use additional paper if needed.
Details:_____
_____

Applicant Name: _____

YES ☐ **NO** ☐ During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice nursing within the past five years?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____ Date of Treatment: _____
Details:_____
_____

YES ☐ **NO** ☐ In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____ Date of Treatment: _____
Details:_____
_____

YES ☐ **NO** ☐ During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice nursing within the past five years?

If yes, please provide details below. Use additional paper if needed.
State:_____County:_____ Date of Treatment: _____
Details:_____
_____

I hereby certify that all information provided on this disclosure form is true, correct, and complete. If any information proves to be incorrect or incomplete, I understand that this will be grounds for denying or terminating my ability to participate in the Nursing Program at the College. I will inform the College immediately if arrested for any of the disqualifying offenses (see Florida Statutes Chapter 435) while enrolled in the Practical Nursing Program. I understand that any arrests for one or more of the disqualifying offenses may result in administrative removal from the program. I also understand that my failure to inform the college of my arrest for any disqualifying offenses will result in immediate administrative removal from the program.

Print Name _____ Date _____

Applicant Signature _____ Date _____

Locklin Technical College uses Digital Trusted Identity Services (DTIS) to fulfill the requirement of Level 2 background screening of applicants/students. Nurses are required to undergo a Level 2 background screening for licensure and employment.

The affiliation agreements between the clinical facilities and Locklin Technical College require our nursing students to undergo the same Level 2 background screening as the nurses they employ. Please see the Florida Statute Chapter 435 on the website www.leg.state.fl.us. The complete chapter can be found under Statute Section Title XXXI – Labor. A list of prohibited criminal offenses is included at the end of the application packet.

When to get fingerprinted: **Between June 01, 2026, and June 12, 2026.**
Do not complete this step before June 01, 2026, or after June 12, 2026.

Directions for Level 2 background screening (fingerprinting):

1. Go to www.dtis.com.
2. Select (click on) "**REGISTER AND SCHEDULE A FINGERPRINT APPOINTMENT**"
3. Select "**CREATE AN ACCOUNT TO GET STARTED**" located in the New Individuals box if this is your first time using DTIS for background screening. You will need to register with DTIS.
4. Create your account by inputting your email address and creating a password. You will be sent an email to validate your email address.
5. After your email address is validated: Sign into your account to complete registration.
6. Set up security questions.
7. Select Product: "**Florida Services**" and click on "**Begin Application Process**"
8. Input Locklin Technical College's **ORI# V57020002** and select "Verify".
9. Verify the information is correct. Your screen should read:
   ORI [COMPANY] [Locklin Tech]
   VECHS Volunteers
10. If the information you see is different: back-up and re-enter the ORI#. If you are fingerprinted under an incorrect ORI you will be charged to process your fingerprints again under the correct ORI number.
11. Complete ALL of the Requested Information. The reason for your request is "**Volunteer**". Leave the OCA blank. After you save your information, you will review and verify its accuracy.
12. Select your appointment location, date, and time and schedule it.
13. Pay for your Background check.
14. You will receive an email with your appointment information and TNC (account number). Save or print this receipt and take it with you to the appointment with a government-issued photo ID.
15. Select "**Logout**" to exit.

FYI:
Do not use the 'back arrows' on your computer screen or you will have to start over.
If you select the options that are not in the instructions, you may have to pay for the fingerprinting again.
Make sure to add all your aliases and addresses.
You must complete each section marked with an asterisk (*).
If you need additional assistance contact DTIS at (703) 797-2562.

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Form A
Florida Department of Law Enforcement
Criminal Justice Information Services Division/User Services Bureau

VECHS WAIVER AGREEMENT AND STATEMENT

Volunteer & Employee Criminal History Systems
(VECHS) For Criminal History Record Checks
under the National Child Protection Act of 1993, as
amended, and Section 943.0542, Florida Statutes

Pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes, this form must be completed and signed by every current or prospective employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize **Locklin Technical College** to submit a set of my fingerprints and this form to the Florida Department of Law Enforcement for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30- 16.34, and that I could then freely disclose any such information to whomever I chose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Qualified Entity with which I am or am seeking to be employed or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes.

I understand that, until the criminal history background check is completed, you may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further understand that, upon request, you will provide me a copy of the criminal history background report, if any, you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or subcontractor.

A national criminal history background check on me has previously been requested by:

_____
(Name And Address Of Previous Qualified Entity) (Year Of Request)

I _____ have **OR** _____ have not been convicted of a crime.
If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below:

_____
_____

I _____ do **OR** _____ do not authorize you to release my criminal history records, if any to other qualified entities.

I am a current or prospective (check one): _____ Employee ✓ Volunteer _____ Contractor/Vendor

Signature: _____ **Date:** _____
Printed Name: _____
Address: _____ City: _____ State: _____
Date of Birth: _____

TO BE COMPLETED BY QUALIFIED ENTITY:
Entity Name: Radford M. Locklin Technical College _____
Address: 5330 Berryhill Road _____ City: Milton _____ State: FL ___
Telephone: 850-983-5700 _____ Fax: 850-983-5715 _____
FDLE Assigned Qualified Entity Number: V57020002 _____

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Prohibited Criminal Offenses FL Statute 435

An excerpt from FL Statutes 435 Criminal Background Check states:

"The security background investigations under this section must ensure that no persons subject to the provisions of this section have been arrested for and are awaiting final disposition of, have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of state law or similar law of another jurisdiction:

Listed below are prohibited criminal offenses.

a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
e) Section 782.04, relating to murder.
f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
g) Section 782.071, relating to vehicular homicide.
h) Section 782.09, relating to the killing of an unborn child by injury to the mother.
i) Chapter 784, relating to assault, battery, and culpable negligence if the offense was a felony.
j) Section 784.011, relating to assault if the victim of the offense was a minor.
k) Section 784.03, relating to battery if the victim of the offense was a minor.
l) Section 787.01, relating to kidnapping.
m) Section 787.02, relating to false imprisonment.
n) Section 787.025, relating to luring or enticing a child.
o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapons on school property.
s) Section 794.011, relating to sexual battery.
t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
u) Section 794.05, relating to unlawful sexual activity with certain minors.
v) Chapter 796, relating to prostitution.
w) Section 798.02, relating to lewd and lascivious behavior.
x) Chapter 800, relating to lewdness and indecent exposure.
y) Section 806.01, relating to arson.
z) Section 810.02, relating to burglary.
aa) Section 810.14, relating to voyeurism if the offense is a felony.
bb) Section 810.145, relating to video voyeurism if the offense is a felony.
cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
gg) Section 825.103, relating to exploitation of an elderly person or disabled adult if the offense was a felony.
hh) Section 826.04, relating to incest.
ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.
kk) Former s. 827.05, relating to negligent treatment of children.
ll) Section 827.071, relating to sexual performance by a child.
mm) Section 843.01, relating to resisting arrest with violence.
nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection and communication.
oo) Section 843.12, relating to aiding in an escape.
pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
qq) Chapter 847, relating to obscene literature.

rr) Section 874.05, relating to encouraging or recruiting another to join a criminal gang.
ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
vv) Section 944.40, relating to escape.
ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
xx) Section 944.47, relating to introduction of contraband into a correctional facility.
yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.
zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been arrested for and is awaiting final disposition of, been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

(4) For the purpose of screening applicability to participate in the Medicaid program, the security background investigations under this section must ensure that a person subject to screening under this section has not been arrested for and is not awaiting final disposition of; has not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to; and has not been adjudicated delinquent and the record sealed or expunged for, any of the following offenses:

(a) Violation of federal law or a law in any state which creates a criminal offense relating to:

1. The delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program, including the performance of management or administrative services relating to the delivery of goods or services under any such program.
2. Neglect or abuse of a patient in connection with the delivery of any health care good or service.
3. Unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
4. Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
5. Moral turpitude, if punishable by imprisonment of a year or more; or
6. Interference with or obstruction of an investigation into any criminal offense identified in this subsection.

(b) Violation of the following state laws or laws of another jurisdiction:

1. Section 817.569, criminal use of a public record or information contained in a public record.
2. Section 838.016, unlawful compensation, or reward for official behavior.
3. Section 838.021, corruption by threat against a public servant.
4. Section 838.022, official misconduct.
5. Section 838.22, bid tampering.
6. Section 839.13, falsifying records; or
7. Section 839.26, misuse of confidential information.

(c) Violation of a federal or state law, rule, or regulation governing the Florida Medicaid program or any other state Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program.

435.06 Exclusion from employment

(1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of a background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity."

The applicant must submit a signed letter, in writing, to Student Services within 10 days of notification (the date on the letter) to notify us that the applicant is contesting the background screening with the agency providing the background information. An applicant, or student, who has been disqualified for a criminal offense has 30 calendar days after notification of denial of enrollment or removal from the program to clear up any mistaken information.