

Lincoln Memorial University
Caylor School of Nursing
Bachelor of Science in Nursing (BSN)
Application for Readmission

Date _____ Student ID # _____
Name _____ Phone (Home) _____
Address _____ Phone (Cell) _____
_____ Email _____

1. Readmission for: FALL ____ SPRING ____ SUMMER ____ YEAR ____

2. Course to which readmission sought:

- | | |
|-----------------------------------|-----------------------------------|
| 1 st Semester | 2 nd Semester |
| <input type="checkbox"/> NURS 320 | <input type="checkbox"/> NURS 310 |
| <input type="checkbox"/> NURS 330 | <input type="checkbox"/> NURS 360 |
| <input type="checkbox"/> NURS 340 | <input type="checkbox"/> NURS 375 |
| <input type="checkbox"/> NURS 350 | |
| | |
| 3 rd Semester | 4 th Semester |
| <input type="checkbox"/> NURS 415 | <input type="checkbox"/> NURS 435 |
| <input type="checkbox"/> NURS 425 | <input type="checkbox"/> NURS 460 |
| <input type="checkbox"/> NURS 430 | <input type="checkbox"/> NURS 470 |
| | <input type="checkbox"/> NURS 480 |

3. Reason(s) for this request:

4. Extenuating circumstances affecting performance in last nursing course attempted:

5. Signature of Student _____

DO NOT WRITE BELOW THIS LINE

COMMITTEE DECISION _____

DATE _____

COMMITTEE MEMBER'S SIGNATURE _____

NOTIFICATION SENT TO STUDENT _____

PROGRAM CHAIR'S SIGNATURE/DATE _____

PLEASE RETURN FORM TO: *Lincoln Memorial University, Caylor School of Nursing, 6965 Cumberland Gap Parkway, Harrogate, TN 37752*