Psychiatric-Mental Health Nurse Practitioners (PMHNPs) are clinical experts prepared to implement a holistic approach to providing mental health care to individuals, families, groups, and communities. The focus of our PMHNP program is to provide the academic knowledge and clinical skills necessary to provide mental health promotion, disease prevention, assessment, and management of psychiatric illness.

During the Mount Marty College PMHNP program, you’ll be trained to use an evidence-based approach to diagnose and treat a variety of mental health conditions through the provision of pharmacotherapy and psychotherapy. Upon graduation, you’ll be prepared to meet the mental health care needs of a variety of rural and underserved populations. Most importantly, you’ll be prepared to take an active leadership role in health care advancements.
Admission Requirements and Application Procedure

Admission Requirements
To be accepted/admitted into the Master of Science Psychiatric-Mental Health Nurse Practitioner, the applicant must meet the following requirements:

• Bachelor’s degree in nursing from a ACEN or CCNE accredited program
• Cumulative GPA of 3.00 on a 4.0 scale
• Current licensure as an RN with at least one year (two years preferred) of professional RN practice
• Completion of Basic Life Support (BLS)
• Three letters of recommendation (must be sent directly to the school)
• Current Resume
• Personal Essay
• An interview will be conducted with each selected applicant as part of the admission process
• Completed health questionnaire, physical exam, immunization record, and criminal background check prior to the start of the first semester, if admitted to the program

Selection Process
The MSN Admissions Committee will carefully review the completed application and supporting material, academic performance, nursing experience, and references. Because class size is limited, not all candidates who meet minimum requirements may be admitted to the program. Interviews will be scheduled with selected applicants. Applicants will be notified of the MSN Admissions Committee decision regarding acceptance into the program within 2 weeks of the personal interview. Incomplete applications, or applications received after the designated deadline, will be reviewed at the discretion of MSN Admissions Committee.

International Students
International students are asked to follow the additional admissions procedures online at:
https://www.mtmc.edu/future-students/new-students/internationalstudents/
All application materials must be received no later than the application deadline for the term of your interest. Incomplete applications, or applications received after the application deadline, will be reviewed only at the discretion of the Admission Committee.

First Name: __________________________________        Last Name: _______________________________________
Email Address: ____________________________________________________________________________________
Phone Number: ____________________________________________________________________________________

Step 1: Complete online Masters of Science in Nursing Application         Date Submitted: ____________

Complete the online application before mailing the completed admission packet or forwarding materials. Supporting application materials cannot be processed until the online application has been completed and your account has been established.

Step 2: Submit the following documents directly to the Mount Marty College Admissions Office.
Do not send directly to MMC Nursing Department.

___ One official transcript from each college/university you attended. In order for transcripts to be considered official, they must be sent directly from the institution to Mount Marty College Admissions Office.

___ Official transcript verification of classes in which you are currently enrolled.

Step 3: Application Packet and Checklist
Submit the following items to the MMC Office of Admission. Do not send directly to MMC Nursing Department.

___ Completed checklist
___ $35 non-refundable application fee made payable to Mount Marty College
___ 3 unopened recommendation forms.
   Give the form to the recommender with a business size envelope (self-addressed and stamped if indicated). The person providing the reference should seal the envelope and place their signature across the flap. The envelope needs to be returned to you, and you will return it unopened in your application packet.
___ Complete immunization record and copies submitted as required by the Mount Marty College Master in Nursing Program
___ Current resume
___ Submission of physical exam and immunization documents that must be completed by a nurse practitioner, physician, or physician assistant
___ Personal Essay
   Essay should describe your goals for graduate study: reasons you selected advanced practice nursing as your career choice and characteristics you offer to this level of practice, service, and research. Essays should be typed and no more than 500 words.
___ Photocopy of your current RN licensure
___ Photocopy of current Basic Life Support (BLS)
___ Photocopy of other certifications you hold
MSN- Psychiatric-Mental Health Nurse Practitioner Admissions Instructions & Checklist
(continued)

Please mark the term of your interest: __ Summer ___ Spring Semester ___ Fall Semester

Mail all materials to:

Admission Office
Mount Marty College
1105 West 8th St
Yankton, SD 57078

By signing this document you are agreeing to the following conditions:

- You are giving Mount Marty College Division of Nursing permission to perform a student background check
- Professional liability insurance will be provided by MMC.
- You are agreeing to attend the MSN Intensive Seminars.
- You are agreeing that you have taken a graduate statistics course and the transcript has been sent or that you will take the Mount Marty graduate statistics course.
- You are agreeing to follow all MSN policies and procedures listed in the MSN Student Handbook and Preceptor Handbook.
- All information contained on this application is correct, complete and honestly represented.

Applicant’s Signature: ______________________________________ Date: ___________________________
**MSN-PMHNP Educational Data Form**

**Educational Data:**
Applicants must possess an appropriate baccalaureate degree from a regionally accredited college or university and have maintained an cumulative GPA of 3.0 on 4.0 scale. Degrees must be completed with final transcripts submitted prior to admission. Baccalaureate degree in nursing is required.

<table>
<thead>
<tr>
<th>Nursing Education</th>
<th>Institution</th>
<th>Date Conferred</th>
<th>GPA</th>
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<tbody>
<tr>
<td>Diploma in Nursing</td>
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<tr>
<td>Associate Degree in Nursing</td>
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<tr>
<td>Bachelor of Science in Nursing</td>
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<tr>
<th>Other Degrees</th>
<th>Institution</th>
<th>Date Conferred</th>
<th>GPA</th>
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RN Licensure Form

Applicant: ____________________________________________________________________________

Last First Middle Other

At least one year (2 years preferred) of recent nursing experience as a RN (mental health experience preferred) is required prior to enrollment. Please indicate experience below.

<table>
<thead>
<tr>
<th>Clinical Job Site</th>
<th>Type of Unit</th>
<th># of Beds</th>
<th>Dates of Employment</th>
<th>Hours worked/week</th>
<th>Total months/years of experience</th>
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Total months/years an RN: ____________________________________________________________________

Total months/years in as an RN: ____________________________________________________________________

Answer the following questions. If yes, submit a letter of explanation.

□ Yes □ No Have you ever been on probation or suspended from any place of employment?

□ Yes □ No Within the last three years, have you ever experienced a physical, emotional or mental condition that endangered the health or safety of persons entrusted in your care?

Certificates/Professional Organizations:
Please include photocopies of all certifications held.

BLS Certification □ Yes □ No Expiration Date: __________________________

CPI Certification (if you have one) □ Yes □ No Expiration Date: __________________________

Other Certifications: _________________________________________________________________________

List the professional organizations you are a member of: _________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
**RN Professional License:**

Applicants must provide proof of licensure as a professional Registered Nurse (RN). Please complete the requested information below. Include a photocopy of your current nursing license(s).

List all states where you have/have had licensure as a professional Registered Nurse (RN).

<table>
<thead>
<tr>
<th>State</th>
<th>Status</th>
<th>License # if active</th>
<th>Expiration Date</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>□ Active □ Inactive</td>
<td>□ Active □ Inactive</td>
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</table>

☐ Yes ☐ No Have you ever had a nursing license suspended or revoked? If so submit a letter of explanation.

☐ Yes ☐ No Have you ever been the subject of a Nursing Board disciplinary action? If yes, submit a letter of explanation.

☐ Yes ☐ No Have you ever been refused a nursing license? If yes, submit a letter of explanation.

☐ Yes ☐ No Are you aware of any disciplinary action pending on your nursing license?

List the state in which you were originally licensed as an RN:

I attest that the information provided in this application is accurate.

Signature: ___________________________ Date: ________________________


**Recommendations by Nursing Director/Manager**

The following is to be completed by applicant. Please type or print:

Applicant: _________________________________________________________________________________________________
Last First Middle Other

I have read and approved this request for information. I voluntarily waive any right of access to this confidential letter of evaluation.

Applicant Signature ____________________________________________ Date ______________________

The following is to be completed by current Nursing Unit Director/Manager.

The Admissions Committee appreciates your cooperation in determining the applicant's potential for success, both as a graduate student and in an advanced practice role as a nurse practitioner. Your candid opinion will be appreciated. This information will be held in confidence if the applicant has signed the above waiver. Please complete your evaluation using the MMC Recommendation Form provided. Place the completed evaluation in the business size envelope provided by the applicant and seal the flap. Next, sign your name across the flap and return it to the applicant. This recommendation is an essential part of the application.

**Applicant's General Information**

Hospital/Medical Center where employed: ________________________________________________________________

Primary Unit: ________________________________
Number of beds ____________________________
Avg. hours worked/week ____________

Secondary Unit (if any): ________________________________
Number of beds ____________________________
Avg. hours worked/week ____________

How long have you known the applicant professionally? ____________________________________________________

**Applicant's Personal Attributes**

Please evaluate the applicant in each of the following categories by checking the appropriate column.

<table>
<thead>
<tr>
<th>Personal Attributes</th>
<th>Excellent</th>
<th>Above Average</th>
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Acceptance of criticism
Communication skills
Reliability
Clinical/professional competence
Critical thinking/analytic abilities
Self-confidence
Potential for advanced practice nursing
Potential for graduate study
Participation as mentor/preceptor
Participation Unit Meetings/Committees

What are the applicant's strengths?

What are the applicant's weaknesses?

Do you believe the applicant has adequate critical care experience to move on to an advanced practice nursing role?

Comments Please provide any additional comments that would be of value to the Admission Committee. Feel free to use the space below or attach a letterhead bearing your signature.

Overall Recommendation: Check one
☐ I highly recommend this applicant  ☐ I recommend this applicant with reservations
☐ I recommend this applicant  ☐ I do not recommend this applicant (please explain under comments)

Evaluator's Information
Name:_________________________________________Title:_________________________________________
Signature:_________________________________________________________________________________
May we contact you for additional information/clarification? _ Yes _ No
If yes, phone number where you can be reached ________________________________________________
Recommendations by Professional Peer

The following is to be completed by applicant. Please type or print:

Last  First  Middle  Other

I have read and approved this request for information. I voluntarily waive any right of access to this confidential letter of evaluation.

Applicant Signature ________________________ Date __________________

The following is to be completed by current Professional Peer:

The Admissions Committee appreciates your cooperation in determining the applicant’s potential for success, both as a graduate student and in an advanced practice role as a nurse practitioner. Your candid opinion will be appreciated. This information will be held in confidence if the applicant has signed the above waiver.

Please complete your evaluation using the MMC Recommendation Form provided. Place the completed evaluation in the business size envelope provided by the applicant and seal the flap. Next, sign your name across the flap and return it to the applicant. This recommendation is an essential part of the application.

Applicant's General Information

Hospital/Medical Center where employed: __________________________

Primary Unit: __________________________

Number of beds __________________

Avg. hours worked/week __________

Secondary Unit (if any): __________________________

Number of beds __________________

Avg. hours worked/week __________

How long have you known the applicant professionally? __________________________

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| Acceptance of criticism | 
| Communication skills | 
| Reliability | 
| Clinical/professional competence | 
| Critical thinking/analytic abilities | 
| Self-confidence | 
| Potential for advanced practice nursing | 
| Potential for graduate study | 
| Participation as mentor/preceptor | 
| Participation Unit Meetings/Committees | 

**What are the applicant's strengths?**

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**Do you believe the applicant has adequate critical care experience to move on to an advanced practice nursing role?**

**Comments** Please provide any additional comments that would be of value to the Admission Committee. Feel free to use the space below or attach a letterhead bearing your signature.

**Overall Recommendation: Check one**

- ___ I highly recommend this applicant
- ___ I recommend this applicant with reservations
- ___ I recommend this applicant
- ___ I do not recommend this applicant (please explain under comments)

**Evaluator's Information**

Name: ___________________________ Title: ___________________________

Signature: ___________________________

May we contact you for additional information/clarification?  ___ Yes  ___ No

If yes, phone number where you can be reached ___________________________
Recommendations by Medical Provider
(MD/DO/CNP/PA-C)

The following is to be completed by applicant. Please type or print:

Applicant ________________________________
Last   First   Middle   Other

I have read and approved this request for information. I voluntarily waive any right of access to this confidential letter of evaluation.

Applicant Signature ________________________________ Date ________________________________

To be completed by current Medical Provider:

The Admissions Committee appreciates your cooperation in determining the applicant’s potential for success, both as a graduate student and in an advanced practice role as a nurse practitioner. Your candid opinion will be appreciated. This information will be held in confidence if the applicant has signed the above waiver.

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Number of beds ________________
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Secondary Unit (if any): ________________________________
Number of beds ________________
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How long have you known the applicant professionally? ________________________________

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Overall Recommendation: Check one

☐ I highly recommend this applicant
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Evaluator’s Information

Name: _______________________________ Title: _______________________________
Signature: ____________________________

May we contact you for additional information/clarification?  _ Yes  _ No

If yes, phone number where you can be reached ________________________________