QR Code is for CGFNS Internal Use Only

Nursing Education Form

The following information identifies the applicant to the Nursing School/Educational Institution where education was received. Ensure this information is correct, then sign and date the form. Provide each populated form to the Nursing School/Educational Institution to be completed and sent directly to CGFNS by the school.

Part A: Personal Information

ID Number:	CT-00207749	Order Number:	APP-00115059
First/Given Name:	Gemma	Date of Birth:	10-08-1973
Middle Name:	Galamgam	Phone Number:	0210414887
Last/Family Name:	Cruz	Email Address:	gemmacruz8@yahoo.com

Name used when attended this school: Gemma G. Galamgam

Name of school of nursing/educational institution: Centro Escolar University-Manila Campus

- Did this school close or merge with another school? No
- If yes, name of institution where transcripts and training records are archived:

Attendance Start Date: 06-04-1990
Attendance End Date: 03-22-1994

I, Gemma Galamgam Cruz, hereby give my consent to Centro Escolar University-Manila Campus to provide the information and documents related to my education requested in this form, and to send this completed form and documents directly to CGFNS at the following address:

For Standard Mail:
CGFNS International, Inc.
ATTN: CVS: NCNZ
P.O. Box 8658
Philadelphia, PA 19101-8658
United States

For Courier Mail:
CGFNS International, Inc.
ATTN: CVS: NCNZ
3600 Market Street, Suite 400
Philadelphia, PA 19104-2651
United States

Applicant Signature:_____ Date Signed 13 April 2023

If you have any questions, please contact CGFNS via phone at +1 267-845-4521 or use the Support option in your CGFNS Applicant Portal.

Part B: Nursing Education/Education Information

To be completed by the official authority: Please provide the following information (**in English**) concerning the education of this applicant. Please spell out all names fully (**no initials or abbreviations**). When sending this form, please be sure to include the applicant's **academic transcripts** as well as **syllabi/course descriptions** for the course of study attended.

Do not leave any fields blank; mark questions that are not applicable as N/A.

Name of your school at the time of the applicant's attendance: _____

Current name of your School:_____

What type of school/educational institution is your institution?

☐ Secondary	☐ Vocational	☐ College
☐ Hospital	☐ University	

What is the primary language used at your educational institution?_____

Name of the student as it appears on the official transcript:_____

Name of the credential/degree obtained: _____

What are the minimum entrance requirements for admission to this program?

_____

_____

What is the prescribed length of the study?_____

Language of Theoretical Instruction:_____

Language of Clinical Instruction:_____

Date this applicant started this program:_____

Did the applicant complete the program? ☐ Yes ☐ No

If Yes, date this applicant gradated or formally competed the program:_____

If No, last date of attendance:_____

How was this program delivered?

☐ On site in class learning	☐ On-Line distance learning	☐ Blended
☐ Other (Explain): _____		

PLEASE SEE NEXT PAGE

Date your institution began offering this program:_____(dd/mm/yyyy)

Date the program was initially accredited/approved:_____(dd/mm/yyyy)

What organization initially accredited/approved this program?_____

Date of most recent accreditation/approval renewal_____(dd/mm/yyyy)

What organization granted the most recent accreditation/approval for this program?_____

Date of current accreditation/approval expiration:_____(dd/mm/yyyy)

Level of accreditation (if applicable):_____

******Please provide the following required additional information/documents with this completed form***:***

Check if included	Check if unavailable*	Description
☐	☐	Official transcript of this applicant's education: This is the official document or record of this applicant's enrollment, progress and achievement within your education institution. The transcript should identify courses taken (title and course number), credits and grades achieved, theoretical and clinical hours and credentials earned. Included with the transcript should be any supporting documents appropriate for education programs in your jurisdiction, such as Related Learning Experience (Philippines), school and university mark sheets (India) and diploma supplements (European Union Countries)
☐	☐	Evidence of Accreditation/Approval of the education program at the time of the applicant's education.

*Please provide an explanation regarding why the document is unavailable to send:_____
_____
_____

CGFNS will verify the authenticity of all documents received. If this is the first time your institution is sending information to CGFNS or if you have changed the appearance (stamp, seal, watermark, hologram, etc.) of your academic records within the past year, please provide a separate document with samples or a description of the authentic documents along with the names and signatures of the people authorized to submit these materials. In addition, please provide the name and direct contact information of the official authority for the purpose of verification.

PLEASE SEE NEXT PAGE

Part C: Nursing Education Domain Breakdown

In addition to attaching a copy of the official transcript of this applicant's nursing education, with a program curriculum and syllabus for each course, please provide specific contact hours (not credit hours) of theoretical instruction, lab and hours of clinical practice for the subject areas listed below. Please do not combine subject areas. If they are combined in the curriculum, please estimate the hours of theoretical instruction and hours of clinical practice in each subject area.

Nursing Domains	Theory Hours	Clinical Hours	Was this Subject taught Independently or Integrated with other subjects?		How much time elapsed between the theoretical and clinical components		
Adult-Medical Nursing			Independent	Integrated	Concurrent	<6 Months	>6 Months
Adult-Surgical Nursing			Independent	Integrated	Concurrent	<6 Months	>6 Months
Maternal/Infant (excluding Gynecology)			Independent	Integrated	Concurrent	<6 Months	>6 Months
Nursing Care of Children			Independent	Integrated	Concurrent	<6 Months	>6 Months
Psychiatric/Mental Health Nursing			Independent	Integrated	Concurrent	<6 Months	>6 Months
Community Health Concepts			Independent	Integrated	Concurrent	<6 Months	>6 Months
Geriatric Nursing (Gerontology)			Independent	Integrated	Concurrent	<6 Months	>6 Months
Physical Assessment			Independent	Integrated	Concurrent	<6 Months	>6 Months

Subjects Area	Theory Hours	Subject Area	Theory Hours	Subject Area	Theory Hours
Anatomy and Physiology		Ethical Considerations		Legal Aspects of Nursing	
Human Growth and Development		Health Counseling		Personal and Family Health Concepts	
Nutrition		Interpersonal Relationships		Professional Roles and Function	
Pharmacology and Administration of Medicine		Leadership in Nursing			

Current address of this educational institution:

Name:_____
Address 1:_____
Address 2: _____
P.O. Box:_____
City/Town:_____
Province/State/Territory:_____
Postal Code/Zip Code:_____
Country:_____

Current address of any affiliated University:

Name:_____
Address 1:_____
Address 2: _____
P.O. Box:_____
City/Town:_____
Province/State/Territory:_____
Postal Code/Zip Code:_____
Country: _____

PLEASE SEE NEXT PAGE

Part D: Identification of Official

To be completed by the official authority. Please provide the following information, and spell out all names fully

(no initials or abbreviations). Mail this completed form and all documents directly to CGFNS.

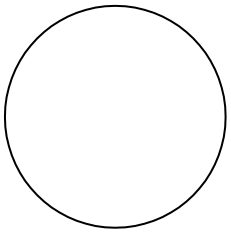
Official authorized to provide transcripts

Printed name: _____ Official Title: _____
Phone Number: _____ Alternate Phone Number: _____
(123-456-7890 format with country code)

Email Address: _____ Website Address: _____
By signing below, I certify all information is true and correct to the best of my knowledge and has been provided by the appropriate primary source.

Official's Signature: _____ Date Signed: _____(dd/mm/yyyy)

[Official signature, date signed, and seal or stamp are required for this document to be accepted.]



In the space to the left, place the official seal or stamp of this organization.

If the official providing the educational instruction information is a different official, please provide the name and signature of this official as well.

Official authorized to provide educational information

Printed name: _____ Official Title: _____
Phone Number: _____ Alternate Phone Number: _____
(123-456-7890 format with country code)

Email Address: _____ Website Address: _____

By signing below, I certify all information is true and correct to the best of my knowledge and has been provided by the appropriate primary source.

Official's Signature: _____ Date Signed: _____(dd/mm/yyyy)

[Official signature, date signed, seal or stamp are required for this document to be accepted.]

Postal Mailing Address	**By Courier**
CGFNS International, Inc. ATTN: CVS-NCNZ P.O. Box 8658 Philadelphia, PA 19101-8658 USA	CGFNS International, Inc. ATTN: CVS-NCNZ 3600 Market Street, Suite 400 Philadelphia, PA 19104-2651 USA

If you have any questions, please contact CGFNS via phone at +1 267-845-4521.