VOCATIONAL NURSING PROGRAM

OPEN ENROLLMENT: - NOVEMBER 2026 | FULL TIME

The Vocational Nursing Program at Meta Polytechnic is a 1,658-hour / 53-week program. The objective of the school is to prepare the students with sufficient theoretical knowledge and specialized practical skills to qualify for an entry-level position as a member of the nursing staff in a variety of health care settings.

SCHEDULE OF CLASSES		
THEORY	TUESDAY - FRIDAY	8:00AM - 4:30PM
CLINICAL	*DAYS VARY*	7:00AM - 3:30PM

PROGRAM COST ***Tuition rates are effective until December 31, 2025, and are subject to change beginning January 1, 2026.***	
Tuition	$39,000.00
Registration Fee (Non-Refundable after cancellation period)	$350.00
Student Tuition Recovery Fund (STRF) (Non-Refundable after the cancellation period) ***Subject to change*	$0.00
Textbooks	$500.00
Student Supplies (Backpack w/ supplies)	$500.00
Uniforms (4 Black Scrubs with school logo)	$300.00
ATI*	$2000.00
	Total $42,650

GRADUATION REQUIREMENTS:

To complete the chosen program the student must:

a. Attend at least 100% of the scheduled hours of instruction (any missed hours must be made up hour-for-hour according to the Make-Up Policy)
b. Attain at least an 80% cumulative overall average (pass)
    i. attain at least 75% average on assigned quizzes or tests (pass)
    ii. attain a grade of “pass” on all skills assessments

VOCATIONAL NURSING PROGRAM APPLICATION CHECKLIST

***SEE PAGE 3** for detailed descriptions of the requirements**

ACADEMIC REQUIREMENTS:

- ☐ META APPLICATION + APPLICATION FEE
- ☐ HIGH SCHOOL DIPLOMA
- ☐ TRANSCRIPTS - HIGH SCHOOL PROOF OF RECEIPT OF GED (GPA 2.5 OR HIGHER)
- ☐ ATI TEAS SCORE RESULTS (SCORE MUST BE 60% OR ABOVE)

DOCUMENTATION REQUIREMENTS:

- ☐ CA I.D. / DRIVER LICENSE
- ☐ SSN (NON LAMINATED, NO COPIES)
- ☐ ACTIVE CERTIFICATE OR LICENSE (CNA, CORPSMAN, CMA, PCT, ERT, HOME HEALTH AID, PARAMEDIC LICENCE)
- ☐ CPR CERTIFICATION (AMERICAN HEART ASSOCIATION)

HEALTH REQUIREMENTS:

- ☐ PHYSICAL EXAM FORM
- ☐ COPY OF IMMUNIZATION RECORDS

EXTRA/OPTIONAL REQUIREMENTS

- ☐ EXTRA: AS/AA DEGREE AND/OR TRANSCRIPTS FROM USA ACCREDITED COLLEGE
- ☐ EXTRA: BS/BA DEGREE AND/OR TRANSCRIPTS FROM USA ACCREDITED COLLEGE
- ☐ EXTRA: CAREGIVER 1 YEAR VERIFIABLE EXP (LETTERHEAD FROM CURRENT/FORMER ORG VERIFICATION)
- ☐ EXTRA: NURSE ASSISTANT 1 YEAR EXP (CA CERT & LETTERHEAD FROM CURRENT/FORMER ORG VERIFICATION)
- ☐ EXTRA: RESUME
- ☐ EXTRA: VETERAN ACTIVE/DISCHARGE IN GOOD STANDING (DD/2-14)
- ☐ EXTRA: VOLUNTEER HEALTHCARE RELATED (LETTERHEAD)

DESCRIPTION OF REQUIREMENTS

- **MINIMUM EDUCATION** | High school or equivalency diploma (GED). Applicants must submit copies of high school transcripts (With a minimum GPA of 2.5), proof of high school graduation, or proof of receipt of a GED prior to starting. *Applicants must be able to read, speak, and write English.
- **AGE REQUIREMENT** | Applicants under the age of 18 may be admitted provided that they will be 18 years old by the scheduled start date of their externship/clinical. A parent, legal guardian, or spouse of legal age is required to co-sign the Enrollment Agreement.
- **PERSONAL INTERVIEW** | The Meta Polytechnic requires a personal, on-campus interview with each applicant prior to acceptance into the Vocational Nursing Program.
- **CRIMINAL BACKGROUND CHECK** | Convictions, guilty pleas or non contendere pleas for certain drug-related, fraud-based, or other serious crimes will disqualify a prospective student.
- **ADMISSIONS EXAM** | ATI/ TEAS **(Test of Essential Academic Skills)** - Applicants must complete the exam and score a 60 or above as part of the application process. TEAS scores taken within the last 12 months will be accepted.
- **PHYSICAL** | A health screening performed by a Physician (Physician or Nurse Practitioner), Immunization records, and the results of certain tests are required.
- **MULTICRITERIA SELECTION PROCESS** | Meta Polytechnic will utilize a Multiple Criteria Selection (MCS) process for admission into the Vocational Nursing Program. The MCS process is a point-based system. The points earned from the criteria determine the candidates ranking in the selection process. Once the 15 candidates are selected for admission, prospective students not selected will be required to reapply for the next available cohort.

If applicable, information regarding the ability-to-benefit examination is required by section 94904 of the Code.

- All Ability-to-Benefit (ATB) students are those who do not possess a high school diploma or GED and may NOT apply for enrollment in the Vocational Nursing Program.

The types and amount of general education required.

- Applicants may be admitted provided that they are high school graduates, and have a high school or equivalency diploma (GED). Applicants must submit copies of high school transcripts, proof of high school graduation, or proof of receipt of a GED prior to starting.

STATEMENT OF NONDISCRIMINATION

No person shall be excluded from participation, denied any benefits, or subjected to any form of discrimination based on race, sex, religion, color, national origin, age, disability, or any other factor protected by law.

VOCATIONAL NURSING PROGRAM INITIAL APPLICATION

Program: VN Program Cohort 2

Program Start Date: November 2025

Program Scheduled Completion Date: December 2026

***Registration Fee $350.00** (*NON REFUNDABLE - Check, Cashier's Check, Money Order only)

*Submit PROGRAM INITIAL APPLICATION and PAYMENT postmarked by the deadline **Friday, October 31, 2025, at 12 PM** to be considered.

Student Name: _____ **Date of Birth:** _____/_____/_____

Address: _____ **City:** _____ **State:** _____

Phone Number: (_____)_____ **Email Address:** _____

State ID #: _____ **SSN:** _____

Emergency Contact: _____ **Phone:** (_____)_____

Highest Level of Education:

- ☐ High School/ G.E.D.
- ☐ Some College
- ☐ 2 Year College (Associate Degree)
- ☐ 4 Year College (BA/BS Degree)
- ☐ Master's Degree or Higher

The student has the right to cancel the enrollment agreement and obtain a refund of charges paid through attendance at the first class session, or the seventh day after enrollment, whichever is later. A notice of cancellation for the current term or from the school shall be in writing and submitted to the school administrative office or via email. Cancellation is effective on the date written notice of cancellation is sent to the school administrative office at 2086 Otay Lake Rd. Suite 201, Chula Vista, CA 91915 Admissions & Student Services Director or by email to LVN@MetaPolytechnic.com If the student has received federal student financial aid funds, the student is entitled to a refund of monies not paid from the federal student financial aid program funds.

My signature below certifies that I have read, understood, and agreed to my rights and responsibilities and that the institution's cancellation and refund policies have been clearly explained to me.

X Student's Signature: _____ **Date:** _____/_____/_____

VOCATIONAL NURSING PROGRAM PHYSICAL EXAM

TO BE COMPLETED BY THE STUDENT:
Disclosure and Release of Health History and Immunization Requirements

Student Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____

Phone Number: (_____)_____ Email Address: _____

State ID #: _____ SSN: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____

DISCLOSURE AND CERTIFICATION STATEMENTS I hereby grant permission for the release and/or disclosure of health history and health screening medical information between and among authorized college, clinical facilities, and hospital personnel.

CONSENT FOR RELEASE OF HEALTH REPORT, RECORDS AND/OR MEDICAL INFORMATION I hereby consent to the communication of my health records from Meta Polytechnic to participating agencies as requested. Furthermore, I acknowledge it is my responsibility to keep current at all times and provide the most current documentation of my physical exam, proof of vaccines and/or titers, TB test results, flu shot and other required health/medical records to Meta Polytechnic School of Vocational Nursing. Once admitted, I will be required to remain compliant at all times.

X Student's Signature: _____ Date: ____/____/____

Physical exams are good for one year

HEALTH HISTORY FORM

Health History – TO BE COMPLETED BY THE STUDENT	**CHECK "YES" or "NO"**	
1. Have you ever been hospitalized? If yes, provide information below.	Yes	No
a. List health problem:	Date:	
b. List operation(s) performed:	Date(s):	
2. Are you under a physician's care now? If yes, provide information below.	Yes	No
a. List name of physician:		
b. List name of health problems:		
c. Are you taking medications on a regular or frequent basis?	Yes	No
If yes, list meds (attach sheet, if needed):		
3. Do you have any allergies?	Yes	No
a. List medications you are allergic to:		
b. List other allergies: (food, pollen, contact, animal, dust):		
4. Have you had a back, neck or wrist injury?	Yes	No
a. Was medical attention or surgery required?	Yes	No
Please explain:		
5. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
a. Was medical attention or surgery required?	Yes	No
Please explain:		
6. Do you smoke? If yes, packs per day = [ ]	Yes	No
For questions 7-9 below: if you answer "yes," please explain your limitation(s) on a		

separate sheet of paper		
7. Do you have any limitation(s) which may affect your ability to lift, turn, or transfer patients or otherwise restrict you from participating fully in the LVN training program?	Yes	No
8. Do you have any limitation(s) in the use of your senses, such as sight or hearing, which would limit your ability to practice a health profession?	Yes	No
9. Do you have any condition which might interfere with your ability to practice a health profession safely? If yes, please explain your limitation(s) in detail on a separate sheet of paper.	Yes	No
PLEASE INDICATE WITH A CHECK IF YOU OR A FAMILY MEMBER HAVE HAD:	SELF	FAMILY MEMBER
a. Hypertension (High blood pressure)		
b. Heart disease		
c. Diabetes		
d. Cancer		
e. Tuberculosis		
f. Seizure disorder		
g. Asthma		
h. Chickenpox		
i. Drug and/or alcohol abuse		

X Student's Signature: _____ Date: _____/_____/_____

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER:

Meta Polytechnic requires a physical examination for students enrolling in the Vocational Nursing Program. A statement of your knowledge of this student's health (mental and physical) will be greatly appreciated. This report goes directly to the Nursing Education Department and will be released only to authorized college, clinical facilities, and hospital personnel. Physical exams are good for one year.

STUDENT'S NAME_____

(PRINT CLEARLY)

BP_____ P_____ R_____ Ht._____Wt._____

	Normal	Abnormal
Vision:		

Right Eye: 20 / _____

Left Eye: 20 / _____

Glasses? Yes / No

Corrective Lens? Yes / No

	Normal	Abnormal
Hearing:		
If Abnormal, please complete the following decibel information		
	Right Ear	Left Ear
500 hz	_____dcb	_____dcb
1000 hz	_____dcb	_____dcb
2000 hz	_____dcb	_____dcb

PHYSICAL EXAM

	Normal	Abnormal	Description
1. General Appearance			
2. Skin			
3. Nodes			
4. Skull			
5. Ears			
6. Eyes			
7. Nose			
8. Oropharynx			
9. Dental			
10. Neck & Thyroid			
11. Chest			
12. Cardiovascular			
13. Abdomen			
14. Hernia Check			
15. Musculoskeletal			
a. Neck			
b. Back			

c. Shoulders			
d. Knee			
e. Ankle			
f. Feet			
g. Other			
16. Neurological			
Comments:			

SUPPLEMENTAL MEDICAL

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER:

- Nursing students must be able to do total patient care in all nursing areas without physical, emotional, cognitive, or psychological limitations.
- Female students must be able to provide care to male patients and male students must be able to provide care to female patients.
- Written documentation of complete recovery from any previous injury and/or illness must be provided.
- The following is a brief description of some of the types of activities that students will perform while working with patients in the hospital. Students are expected to meet all these parameters. Note: Any issues regarding disabilities (temporary or permanent) will be reviewed per ADA Act 1990 and reasonable accommodations will be considered per regulation.

1. Moderate to heavy lifting and carrying (20-40 pounds).
2. Pushing, pulling, bending, and kneeling around patients using various types of hospital equipment such as wheelchairs, gurneys, lifting devices and specialized beds; work in small, confined spaces, move around rapidly.
3. Fine motor dexterity using both hands while preparing medications and manipulating a variety of instruments and assessment devices.
4. Rapid mental processing and simultaneous motor coordination; necessary to manipulate syringes, start IV's; assist with patient ADL's; write/type; perform procedures.
5. Extensive periods of walking and standing (4 or more hours at one time).
6. Visual discrimination including depth perception and color vision; vision sufficient to make physical assessments of patients and equipment; perform procedures.
7. Ability to hear the spoken word in settings where other sounds are present. Able to hear clearly on the telephone, hear through a stethoscope (sound enhanced OK), to hear cries for help, to hear alarms on equipment and emergency signals and various overhead pages.
8. Working with hands in water (frequent hand washing is required); ability to palpate superficially and deeply; discriminate tactile sensations.

9. Working with various materials and substances to which some individuals may be allergic (such as latex).
10. Ability to speak clearly to communicate with patients, families, staff, physicians; need to be understood on the telephone.
11. Have sufficient emotional stability to perform under stress (both academically and in a clinical setting).
12. Ability to communicate effectively in English both verbally and in written format for the classroom setting and the clinical setting. Note: Casts, splints, braces are not allowed in the clinical setting.

Mark the appropriate box below:

- ☐ After reviewing the "Supplemental Medical Guidelines" listed above and based on findings from the patient's history and physical exam, I certify that the above student is physically and mentally capable of fully participating in Meta Polytechnic Vocational Nursing Program.
- ☐ The following health problem(s) should be further evaluated PRIOR to participation in a clinical assignment: _____

Examiner's Signature & Title:_____

Physical Exam Date: _____/_____/_____

License # (required): _____

The statement below is to be reviewed and signed by the student:

I understand these physical and other requirements for the Vocational Nursing Program as specified above. I will inform my healthcare provider, faculty, and the Program Director of any/ all disability issues immediately as they occur, and upon acceptance into the program. If applicable, I will make an appointment with Disability Services with any concerns or disability issues.

X Student's Signature: _____ **Date:** _____/_____/_____

IMMUNIZATION REQUIREMENTS

This form must be completed and signed by a Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, Vocational Nurse, or Pharmacist. A copy of immunization records, and/or titers (lab results) must be included with this form for any vaccine or titer given.

STUDENT'S NAME_____

(PRINT CLEARLY)

MMR (Measles, Mumps, Rubella) vaccine	Date #1:____/_____/_____ Signature: _____ Date #2:____/_____/_____ Signature: _____
MMR Titers (Blood Test)	
Measles: Immune / Not Immune Mumps: Immune / Not Immune Rubella : Immune / Not Immune	Titer Date:____/_____/_____ Signature: _____ Titer Date:____/_____/_____ Signature: _____ Titer Date:____/_____/_____ Signature: _____
Hepatitis B vaccine	Date #1:____/_____/_____ Signature: _____ Date #2:____/_____/_____ Signature: _____ Date #3:____/_____/_____ Signature: _____
Hepatitis B Titer (Blood Test) Immune / Not Immune	Titer Date:____/_____/_____ Signature: _____
Varicella vaccine (Chickenpox)	Titer Date:____/_____/_____ Signature: _____ Titer Date:____/_____/_____ Signature: _____

Varicella Titer (Blood Test) Immune / Not Immune	Titer Date:____/_____/_____ Signature: _____
Tetanus/Diphtheria and Acellular Pertussis vaccine (TDAP) Must be within 10 years Covid 19 vaccine (Only Moderna, Pfizer and Johnson & Johnson's Janssen vaccines accepted)	Date #1:____/_____/_____ Signature: _____ Date #1:____/_____/_____ Signature: _____ Date #2:____/_____/_____ Signature: _____ Date #3:____/_____/_____ Signature: _____

TUBERCULOSIS CLEARANCE

STUDENT'S NAME_____

(PRINT CLEARLY)

- All Health Profession students are required to have a 2-Step PPD (two negative TB skin tests) or a blood test for TB infection (per CDC, these include IGRA's; QuanitFERON; SPOT TB test or T-Spot; or GAMMA INTERFERON) prior to starting program, unless previously positive.
    - If TB test is positive, documentation must be provided, and a chest x-ray is required. Chest x-ray results must be dated within five years.

This form must be completed and signed by a Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, or Vocational Nurse.

STEP #1 - First PPD Test	
Date: ____/_____/_____ Time Given:	Manufacturer: _____ Dose: 0.1mL Exp. Date: ____/_____/_____ Given By:
Date: ____/_____/_____ Time Read:	Results: _____mm Read By:
STEP #2 - Second PPD Test (7-21 days after Step #1)	
Date: ____/_____/_____ Time Given:	Manufacturer: _____ Dose:0.1mL Exp. Date: ____/_____/_____ Given By:

Date: ____/_____/_____ Time Read:	Results: _____mm Read By:

OR

BLOOD TEST for TB Infection (per CDC: IGRA's; QuanitFERON; SPOT TB test or T-Spot; or GAMMA INTERFERON)	
Date: ____/_____/_____	☐ Negative ☐ Positive Signature: _____ (A copy of the lab report must be submitted with this form)

(ONLY if positive TB test result, Chest X-Ray required. Proof of positive TB is required for Chest X-Ray to be valid)

Chest X-Ray	
Chest X-Ray Date: ____/_____/_____	☐ Negative ☐ Positive Signature: _____ (A copy of the chest X-Ray report must be submitted with this form AND proof of positive PPD history)

ANNUAL INFLUENZA VACCINATION CONSENT

- All students/faculty with clinical assignments must comply with the CDC's recommendations for seasonal flu immunization or otherwise announced by a clinical agency.
- There are many different flu viruses, and they are constantly changing. Detailed information about the flu season and vaccines available can be accessed through the CDC's website: https://www.cdc.gov/flu/index.htm.

Please answer the following questions.
It is recommended you wait at least 30 minutes after the injection, due to the possibility of an allergic reaction.

1. Is this the first "Flu" vaccination you have ever received?	Yes	No
2. Have you ever had an allergic or serious reaction to the following; Flu vaccine, chicken eggs, or chicken products, Thimerosal, or have you had Guillain-Barre Syndrome (GBS)?	Yes	No
3. Are you ill today?	Yes	No
4. Do you take blood thinners such as Aspirin, Clopidogrel (Plavix), Dipyridamole (Aggrenox), or Coumadin (Warfarin) or others on a daily basis?	Yes	No
5. Are you under 18 years of age? If yes, parental consent is required.	Yes	No
6. Are you pregnant? If yes, you must provide written permission from your physician.	Yes	No

Please check your appropriate age group and category:

- ☐ 6-18
- ☐ 19-49
- ☐ 50-59
- ☐ 60-64
- ☐ Over 65

Category

- ☐ Student
- ☐ Faculty

I have read the CDC Influenza vaccine information statement. By signing below, I understand and consent to receive the vaccine.

STUDENT'S NAME:_____

(PRINT CLEARLY)

X Student's Signature: _____ **Date:** _____/_____/_____

Manufacturer: _____

Lot #: _____

Exp. Date: ____/_____/_____

Route: IM

Site:

- ☐ R Deltoid
- ☐ Left Deltoid
- ☐ FluMist

Influenza Vaccine

Staff Signature _____ Date _____

STAMP of PROVIDER:

STUDENT ACKNOWLEDGEMENT

As a prospective student, you are encouraged to review this catalog prior to signing an enrollment agreement. You are encouraged to review the School Performance Fact Sheet, which must be provided to you prior to signing an enrollment agreement.

I certify that I have received the catalog, School Performance Fact Sheet, and information regarding completion rates, placement rates, license examination passage rates, and salary wage information, and the most recent three-year cohort default rate, if applicable, included in the School Performance Fact Sheet.

I understand that this is a legally binding contract. My signature below certifies that I have read and understand, and agree, to my rights and responsibilities, and that the institution's cancellation and refund policies have been clearly explained to me.

X Signature of Student: _____ Date:_____/_____/_____