

**CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES
LPN HEALTH ASSESSMENT COURSE
REGISTRATION FORM (EASTERN HEALTH)**

SECTION I

CLPNNL LICENSE NO. _____

PLEASE INDICATE YOUR ORDER OF PREFERENCE (1-4) OF COURSE OFFERINGS:

FALL 2010 (SEPT 7 – DEC 10) _____ WINTER 2011 (JAN 10 – APRIL 15) _____

SPRING 2011 (APR 18 – JULY 29) _____ FALL 2011 (SEPT 6 – DEC 9) _____

First Name Middle Name Last Name Maiden Name

Street Address City/Town Province Postal Code

Phone (Home) Phone (Business) Phone (Cell) Fax Number

Valid E-Mail Address (Compulsory) Emergency Contact Person Telephone

CPR certification date CPR expiry date

SECTION II: PAYMENT

II a. Cheque [] Cash [] Credit Card [] Debit [] * Sponsor []

Amount Paid: _____

Cheque or money order should be made payable to the Centre for Nursing Studies.

Master Card / VISA Cardholder's Name: _____

Master Card/Visa # _____ Expiry Date: _____

IIb. * Sponsored students must complete the following information.

Sponsoring Agency:	Contact Person:
Address:	
Phone No.	Fax No.
	E-Mail:

The CNS acknowledges and respects privacy of individuals. The personal information included on this form is collected under the authority of Sections 32 and 33 of the *Access to Information and Protection of Privacy Act* and will be used for processing your application and for the administration of student records. Direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor, Southcott Hall, 777-8025.

SECTION III: POST SECONDARY EDUCATION (University, Technical, Vocational, Nursing, Workshops, In-Services, First Aid, CPR, Etc.)

Institution	Location	Program Of Study	Certificate / Diploma	Year/s Attended

SECTION IV: REFERENCES: Please print the name, full address, and telephone number of the individual providing your reference.

Name: _____ Phone Number: _____
 Address: _____

SECTION V: EMPLOYMENT HISTORY (beginning with most recent):

Current Employing Health Board: _____ Current Work Site: _____
 Immediate Supervisor/Manager: _____ Phone Number: _____

Other Employment in Nursing: _____

I hereby verify that the information given on this Registration Form is correct. I agree to be governed by the policies, rules, and regulations as set forth by the Centre for Nursing Studies.

Permission is granted to The Centre for Nursing Studies to: i) contact previous employers and/or educational institutions to obtain personal references, to verify educational background, and/or to provide the clinical preceptor with this information ii) provide verification of successful course completion to the licensing body and/or sponsoring agency.

PLEASE NOTE: LEARNER CANNOT COMMENCE THE COURSE UNTIL A COPY OF ACTIVE CLPNNL LICENSE IS SUBMITTED.

 Signature of Learner Date