

**CENTRE FOR NURSING STUDIES  
CONTINUING NURSING STUDIES**

**RN HEALTH ASSESSMENT COURSE**

**REGISTRATION FORM**

**SECTION I**

ARNNL Registration No. \_\_\_\_\_

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|            |             |           |             |
|------------|-------------|-----------|-------------|
| First Name | Middle Name | Last Name | Maiden Name |
|------------|-------------|-----------|-------------|

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|                |           |          |             |
|----------------|-----------|----------|-------------|
| Street Address | City/Town | Province | Postal Code |
|----------------|-----------|----------|-------------|

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

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

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|                        |                 |
|------------------------|-----------------|
| CPR certification date | CPR expiry date |
|------------------------|-----------------|

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|   |   |
|---|---|
| Desired Date to Commence Program/Course | Number of years since last practicing as RN |
|---|---|

**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, 12<sup>th</sup> 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LEARNER CAN NOT COMMENCE COURSE UNTIL COPY OF ACTIVE RN LICENSE IS SUBMITTED.**

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.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Learner