

**CENTRE FOR NURSING STUDIES  
CONTINUING NURSING STUDIES**

**LPN MEDICATION ADMINISTRATION COURSE**

**REGISTRATION FORM**

**INTRAVENOUS THERAPY AND BLOOD AND BLOOD PRODUCT ADMINISTRATION**

**SECTION I**

**CLPNNL LICENSE NO.** \_\_\_\_\_

First Name	Middle Name	Last Name	Maiden Name
Street Address	City/Town	Province	Postal Code
Phone (Home)	Phone (Business)	Phone (Cell)	Fax Number
E-Mail Address (Compulsory)	Emergency Contact Person	Telephone	
CPR certification date	CPR expiry date		

Desired Date to Commence Course \_\_\_\_\_ Number of years since last practicing as an LPN \_\_\_\_\_

**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.)

<b>Institution</b>	<b>Location</b>	<b>Program Of Study</b>	<b>Certificate / Diploma</b>	<b>Year/s Attended</b>

**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 CANNOT COMMENCE COURSE UNTIL COPY OF ACTIVE CLPNNL 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