CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES

LPN MEDICATION ADMINISTRATION COURSE

REGISTRATION FORM

IMMUNIZATIONS MODULE

(Can only be completed on successful completion of IM and ID modules)

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, 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: ______________________________

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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.

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Date Signature of Learner