

**CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES**

LPN POST BASIC PROGRAM IN MENTAL HEALTH

REGISTRATION FORM

SECTION I

CLPNNL LICENSE No. _____

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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	Yes or No	
Desired Date to Commence Program/Course	# years practicing as LPN	Mental Health Experience If yes, # years _____

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: _____

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