

**CENTRE FOR NURSING STUDIES  
CONTINUING NURSING STUDIES**

**RN POST BASIC GERONTOLOGY PROGRAM**

**REGISTRATION FORM**

**SECTION I**

ARNNL LICENSE # \_\_\_\_\_

---

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 Program/Course	Number of years since last practicing as an 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:

**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 ARNNL 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

**FAX NUMBER: 709-777-8176**

The CNS acknowledges and respects the 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, the administration of student records, and coordinating your academic program. Contact information may be shared with other agencies as it pertains solely to the administration of the program/course for which you have applied or as authorized by law. If you have any questions about the collection, use, or disclosure of information on this form, please contact Dr. Anne Kearney, Director, Centre for Nursing Studies at 777-8160.