CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES

LPN POST BASIC GERONTOLOGY COURSE

REGISTRATION FORM

SECTION I

CLPNNL 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 LPN

SECTION II:

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: ____
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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.

_________________________________ ____

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 call 709-777-8160.