CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES

LPN POST BASIC COMPETENCY MODULES

REGISTRATION FORM

Modules are $100.00.

Please indicate which module(s) you wish to register for:

- ☐ Intramuscular Injection Module
- ☐ Intravenous Therapy Administration Module
- ☐ Blood and Blood Products Administration Module – ***Prerequisite: IV Therapy Administration Module***
- ☐ Intradermal Injection Module
- ☐ Immunizations Module – ***Prerequisite: IM and ID modules***
- ☐ Intravenous Medication Administration Module – ***Prerequisite: IV Therapy Administration Module***
- ☐ Intravenous Initiation Module
- ☐ Wound Care Module
- ☐ Hypodermoclysis Module – ***Prerequisite: IV Therapy Administration Module***
- ☐ Central Venous Access Device (CVAD) Module – ***Prerequisite: IV Therapy Administration Module***

SECTION I **CLPNNL LICENSE NO. _________**

First Name Middle Name Last Name Maiden Name

Mailing Address City/Town Province Postal Code

Phone (Home) Phone (Business) Phone (Cell) Fax Number

E-Mail Address (Compulsory) Emergency Contact Person Telephone

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: ____
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COPY OF ACTIVE CLPNNL LICENSE IS REQUIRED.

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 Student

FAX NUMBER: 709-777-8176