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
- ☐ 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: _____

A *non-refundable* 1.75% convenience fee will be applied to credit cards.

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: _____
_____
_____

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