CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES

POST BASIC COURSE IN PERIOPERATIVE NURSING FOR REGISTERED NURSES

REGISTRATION FORM

SECTION I

CRNNL Registration No._____

First Name	Middle Name	Last Name	Maiden Name
Street Address	City/Town	Province	Postal Code
Phone (Home)	Phone (Business)	Phone (Cell)	Social Insurance Number
E-Mail Address (Compulsory)	Emergency Contact Person		Telephone
CPR certification date	CPR expiry date	BLS certification date	BLS expiry date
Desired Date to Commence Program/Course	Number of years since last practicing as RN		

SECTION II:

II a. Cheque [ ] Cash [ ] Credit Card [ ] Debit [ ] ***** Sponsor [ ]

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.

II b. * 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 names, full addresses, and telephone numbers of two individuals providing your references.

Name: _____ Phone Number: _____
Address: _____

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 RN 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 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 the Centre for Nursing Studies at 709-777-8160.