

**CENTRE FOR NURSING STUDIES  
CONTINUING NURSING STUDIES**

**LPN POST BASIC COMPETENCY MODULES**

**REGISTRATION FORM**

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**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.** \_\_\_\_\_

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First Name	Middle Name	Last Name	Maiden Name
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Mailing Address	City/Town	Province	Postal Code
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Phone Number	E-Mail Address (Compulsory)
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SIN Number	Emergency Contact Person	Telephone
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**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.)

<b>Institution</b>	<b>Location</b>	<b>Program Of Study</b>	<b>Certificate / Diploma</b>	<b>Year/s Attended</b>

**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**