

**CENTRE FOR NURSING STUDIES
CONTINUING NURSING STUDIES**

LPN POST BASIC COURSE IN MENTAL HEALTH

REGISTRATION FORM

SECTION I PERSONAL INFORMATION

CLPNNL LICENSE No. _____

First Name	Middle Name	Last Name	Maiden Name
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Street Address	City/Town	Province	Postal Code
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Phone Number	E-Mail Address (Compulsory)	Social Insurance Number
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Emergency Contact Person	Telephone
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CPR certification date	CPR expiry date	# years practicing as LPN
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Yes or No

Mental Health Experience	Acute (# of years) _____	Community (# of years) _____
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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 2.50% 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 and Location	Program of Study	Length of Program	Certificate / Diploma	Year Graduated

SECTION IV: REFERENCES: Please print the name, full address, and telephone number of the individual providing your reference.

Name: _____ Phone Number: _____
 Address: _____
 Relationship to Applicant: _____

SECTION V: EMPLOYMENT HISTORY (Mandatory, beginning with most recent):

Current Employing Health Board: _____ Current Work Site: _____
 Immediate Supervisor/Manager: _____ Phone Number: _____

Other Employment in Nursing: _____

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

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 709-777-8162.

FAX NUMBER: 709-777- 8176