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***
☐ Wound Care

SECTION I STUDENT INFORMATION **CLPNNL LICENSE NO.** ____________

First Name Middle Name Last Name Maiden Name

Mailing Address City/Town Province Postal Code

Phone Number E-Mail Address (Compulsory) SIN Number

Emergency Contact Person Emergency Contact Phone Number

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.

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 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: ____
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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 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 contact the Centre for Nursing Studies at 777-8162.

FAX NUMBER: 709-777-8176