

**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*
- Wound Care

**SECTION I STUDENT INFORMATION**

**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)	SIN Number
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Emergency Contact Person	Emergency Contact Phone Number
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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: \_\_\_\_\_ CV Code: \_\_\_\_\_

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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**