

**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:

- 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

SECTION I

CLPNNL LICENSE NO. _____

First Name	Middle Name	Last Name	Maiden Name
Mailing Address	City/Town	Province	Postal Code
Phone (Home)	Phone (Business)	Phone (Cell)	Fax Number
E-Mail Address (Compulsory)	Emergency Contact Person	Telephone	

SECTION II: PAYMENT

The Centre for Nursing Studies accepts online payment by Visa and MasterCard. A *non-refundable* 1.75% convenience fee will be applied to credit cards. Online payments can be completed at <https://www.centrefornursingstudies.ca/PNTuitionFeesandCharges.php>

Payment by cash, cheque or debit card can be made by visiting the Business Office at Southcott Hall during regular business hours.

For payment by mail, please use:

Business Office
Centre for Nursing Studies
Southcott Hall
100 Forest Road
St. John's, NL A1A 1E5
Canada

*** 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 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