



VERIFICATION OF NURSE EDUCATION

SECTION 1 (completed by applicant)

Complete Section 1 and forward to your nursing school(s) to complete Section 2. Once completed, the form must be mailed directly from the nursing school(s) to CLPNA. Copies will not be accepted, and documents must be translated to English. This form is mandatory for applicants who graduated before 2009. This form may be requested by the CLPNA as needed to further assess educational competencies.

PERSONAL (Please Print)

Current Legal Surname (Last Name)

Given Name (First Name)

Middle Name(s)

Maiden Name

Date of Birth (dd/mm/yy)

Sex Female Male

Apartment / Box No. / Address or Street No.

City / Town / Village

Province/State

Country

Postal Code / Zip Code

Telephone No.

Cell No.

Primary Language

E-mail Address

CONSENT TO RELEASE INFORMATION

I am seeking registration as a Licensed Practical Nurse in Alberta. I authorize _____ (name of Nursing School) to complete Section 2 of this form and mail the required documentation directly to the College of Licensed Practical Nurses of Alberta (CLPNA).

Applicant Signature (do not print)

Date (dd/mm/yy)

SECTION 2 (completed by nursing school)

NURSING EDUCATION (Please Print)

Name of Nursing Program

Name of Educational Institution

Address(Street No./City/Province/Country/Postal Code/Zip Code)

Phone (including area code)

Language of Instruction

Date of Admission (dd/mm/yy)

Graduation Date (dd/mm/yy)

Credential Received

Degree

Diploma

Certificate



NURSING COMPETENCIES CONTINUED (please check if the following competencies were part of the nursing program.)

Health Assessment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medication Administration/Pharmacology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infusion Therapy (maintenance of IV only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Subcutaneous Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pediatrics (Quebec Only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Maternity (Quebec Only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ACTING ON BEHALF OF THE NURSING SCHOOL

 Designate Name (please print)

 Title

 Signature of Designate

 Date (dd/mm/yyyy)

 Email

 Phone Number

