



VERIFICATION OF REGISTRATION

Complete Section 1 and forward to the appropriate registration/nursing board(s) to complete Section 2. Once completed, the form must be mailed or emailed directly from the registration/nursing board(s) to CLPNA. Copies will not be accepted.

SECTION 1 (completed by applicant)

PERSONAL (Please Print)

Current Legal Surname (Last Name)	Given Name (First Name)	Middle Name(s)
Maiden Name	Date of Birth (dd/mm/yy)	Sex <input type="checkbox"/> Female <input type="checkbox"/> 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		

EDUCATION (Please Print)

Name of Nursing Program	Name of Educational Institution	Graduation Date (dd/mm/yy)
Educational Institution Complete Address		

REGISTRATION (Please Print)

Name of Registration/Nursing Board	Initial Registration Date with Board (dd/mm/yy)	Registration Number
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CONSENT TO RELEASE INFORMATION

I am seeking registration as a Licensed Practical Nurse in Alberta. I authorize _____ (name of Registration/Nursing board) 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)
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SECTION 2 (completed by registration/nursing board)

THIS CERTIFIES THAT (Please Print)

_____	_____	_____
Current Legal Surname (Last Name)	Given Name (First Name)	Middle Name(s)
_____		_____
Nursing School/Educational Program		Completion Date (dd/mm/yy)
_____		Registered by <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement
Educational Facility Address		
_____	_____	_____
Initial Registration Date (dd/mm/yy)	Expiry Date (dd/mm/yy)	Registration Number
_____	_____	_____
Name of Examination Written	Date Examination Written (dd/mm/yy)	Language of Examination
_____	_____	_____
Number of Times Examination was Written _____	Results	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Current Status	<input type="checkbox"/> Registered <input type="checkbox"/> Inactive	

FORMAL ACTIONS

- Has the applicant's registration ever been revoked, suspended, or under review? Yes No
- Has the applicant's registration ever been made subject to conditions, limitations, restrictions, and/or an agreement with the board? Yes No
- Has the applicant ever voluntarily surrendered their registration with the board and/or any other jurisdiction? Yes No
- Has the applicant ever been denied registration? Yes No
- Is there now or has there ever been any formal disciplinary action commenced against the applicant? Yes No
- Have there ever been any formal sanctions imposed against the applicant as a matter of public record? (If yes, attach a certified copy of disciplinary action.) Yes No
- Is the applicant the subject of a current investigation, proceeding, outstanding, and/or unresolved complaint against them in relation to their practice of nursing? Yes No

If "Yes" is the answer to any of the questions, please attach documentation outlining action(s) taken.

ACTING ON BEHALF OF REGISTRATION, BOARD, OR COUNCIL

_____	_____
Signature of Registrar/Designate	Print Name
_____	_____
Title	Email
_____	_____
Name of Licensing Authority/Jurisdiction	Date (dd/mm/yy)

