COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

St. Albert Trail Place
13163 -146 Street
Edmonton, AB T5L 4S8

Phone 780.484.8886
Toll Free 1.800.661.5877
Fax 780.484.9069
www.clpna.com

ADVANCED PRACTICE APPLICATION

PERSONAL (Please Print)

Current Legal Surname (Last Name) _____

Given Name (First Name) _____

Middle Name(s) _____

Maiden Name _____

Date of Birth (dd/mm/yy) _____

Gender ❒ Female ❒ Male ❒ Unspecified

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 _____

Registration Number _____

ADVANCED PRACTICE INFORMATION

Under the Government Organization Act, Restricted Activities are high risk health services identified to require a level of professional competence to be performed safely. Regulated professionals must be authorized by their College to perform Restricted Activities. Most Restricted Activities are authorized through entry-level LPN education; however, there are six Restricted Activities that require Advanced Authorization. Three of those Restricted Activities fall under Areas of Advanced Practice requiring completion of education approved by the CLPNA, authorization by the Registrar and a specific application to be completed. The LPN must be authorized by the CLPNA Registrar to engage in Advanced Practice in the following areas:

- Advanced Practice Orthopedics
- Advanced Practice Perioperative
- Advanced Practice Foot Care

In order to be approved for authorization in one of these areas applicants must have completed advanced training approved by the CLPNA Council. If you do not have advanced training approved by the CLPNA please indicate if you wish to have equivalency assessed in Advanced Practice Orthopedics, Advanced Practice Perioperative, or Advanced Practice Foot Care by completing the Advanced Practice Application and requesting original educational transcripts and/or certificates and course objectives to be sent to the CLPNA. Additionally, you will need to request a job description from any employers where you have previously performed the Restricted Activity outside of Alberta. There may be an additional fee for this evaluation.

If you are not seeking authorization to practice in one of these areas of Advanced Practice but intend on practicing in Hemodialysis, Administration of Medication by CVC, PICC or IVAD and/or Administering Parenteral Nutrition please review the CLPNA website for how to obtain authorization in these areas.

Once your Advanced Practice is approved by the CLPNA, it will be indicated on your practice permit and will be displayed on the Public Registry. For a more complete explanation of Restricted Activities and Advanced Practice please see the CLPNA *Standards of Practice on Restricted Activities and Advanced Practice.*

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DECLARATION OF AREAS OF ADVANCED PRACTICE (Please Print: check applicable boxes)				Do you intend to pursue work within this area in Alberta?
Advanced Practice	**Educational Facility**	**Completion Date**	**Original Transcript or Certificate Submitted (yes or no)**	**If you are, you will need to receive authorization from CLPNA prior to practicing within this Restricted Activity**
❒ Orthopedics				
❒ Perioperative				
❒ Foot Care				

ADDITIONAL APPLICATION REQUIREMENTS

❒ I have included a clear copy of the certificate of completion to the CLPNA by email to info@clpna.com.

❒ I will pay the $100 non-refundable application fee on myCLPNA account once available.

❒ I have requested the educational facility to submit original transcripts and course objectives to the CLPNA by mail *(only required for graduates of programs NOT approved by CLPNA)*.

❒ I have requested original job description(s) be sent to the CLPNA by mail for any positions I've practiced the Restricted Activities in previously *(only required for graduates of programs NOT approved by CLPNA)*.

❒ I understand all my documentation must be translated to English before it is submitted to the CLPNA office.

DECLARATION

I hereby declare that I am the person making application for registration as a Licensed Practical Nurse in Alberta and that all statements are true and complete in every respect. I understand that falsification of information on this application may result in the cancellation of my application for registration or cancellation of any registration, which may be issued.

The Privacy Statement should be amended as follows: I acknowledge that the information collected in this form will be used for the purposes of assessing my application for registration. This information will be maintained on my file and may also be used to assess my application for renewal of my practice permit in the future or for the purposes a discipline proceeding under Part 4 of the Health Professions Act. Information collected in this form including geographical, education, and employment information may also be disclosed to non-profit organizations and institutions for the purposes of health policy making and health human resource planning. No other disclosure of this information will be made except in accordance with the provisions of the Health Professions Act, the Licensed Practical Nurses Professions Regulation, the Personal Information Protection Act, or as otherwise permitted by law.

_____ Signature of Applicant (do not print)	_____ Date