



ADVANCED PRACTICE APPLICATION

PERSONAL (Please Print)

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



LICENSED PRACTICAL NURSE

ADVANCED PRACTICE APPLICATION

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
<input type="checkbox"/> Orthopedics				
<input type="checkbox"/> Perioperative				
<input type="checkbox"/> Foot Care				

ADDITIONAL APPLICATION REQUIREMENTS
<input type="checkbox"/> I have included a clear copy of the certificate of completion to the CLPNA by email to registration@clpna.com .
<input type="checkbox"/> I have included the \$100 non-refundable application fee. (Visa/Mastercard payable on the credit card authorization form, certified cheque or money order payable to CLPNA. Please do not mail cash)
<input type="checkbox"/> I have requested the educational facility to submit original transcripts and course objectives to the CLPNA by mail (<i>only required for graduates of programs NOT approved by CLPNA</i>).
<input type="checkbox"/> 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 (<i>only required for graduates of programs NOT approved by CLPNA</i>).
<input type="checkbox"/> 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.		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Signature of Applicant (do not print)</td> <td style="width: 50%; border-bottom: 1px solid black;">Date</td> </tr> </table>	Signature of Applicant (do not print)	Date
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