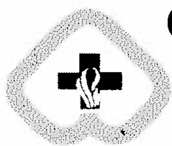
2010 RENEWAL FORM - Complete Both Sides

NEW! Register online at www.clpnbc.org
Click on "renew online"



College of Licensed Practical Nurses of BC

260 - 3480 Gilmore Way, Burnaby, BC V5G 4Y1
Tel: 778.373.3100 • Toll Free Within BC: 1.877.373.2201
E-mail: info@clpnbc.org • Website: www.clpnbc.org

FOR OFFICE USE

Amount Paid $ ______

☐ Credit Card ☐ Money Order ☐ Payroll Deduction ☐ Debit ☐ Cash

Authorization No. ______

1 STATUS REQUESTED Select one box.

☐ Full $225.00 ☐ Non-Practising Renewal $175.00 ☐ I Will Not Be Renewing

2 PAYMENT METHODS - NO PERSONAL CHEQUES. DO NOT MAIL CASH.

☐ Visa
☐ MasterCard
☐ Bank Draft or Money Order
☐ Cash/Debit
☐ Payroll Deduction

Cardholder Name: ______
Card Number: ______
Expiry Date: Month ______ Year ______

Signature of Cardholder ______

3 CRIMINAL RECORD

1. Have you ever been found guilty of a criminal offence for which a PARDON has **NOT** been granted? ☐ Yes ☐ No
2. Are there any criminal charges pending against you currently? ☐ Yes ☐ No

4 CONSENT & DECLARATION FOR REGISTRATION

Consent and Declaration

In making application to renew my registration I hereby consent to the release of personal information to the College from any source identified by the College. This includes but is not limited to: present and past employers, other regulatory or professional bodies, any law enforcement agency or Court, medical, or educational records. Further, I agree to notify the College should any information on this form change, or otherwise become incomplete.

Information on this form is protected and is collected and disclosed in accordance with the laws in the province of British Columbia. Providing false information is an offence and may result in the immediate cancellation of my license and disciplinary action.

I declare that the information contained in this form is accurate and complete. I declare that I am of good character and am fit to practice, and will abide by the requirements of the Health Professional Act, Regulation, and Bylaws of the College.

INCOMPLETE OR UNSIGNED FORMS WILL BE RETURNED.
REINSTATEMENT FEES WILL BE THE APPLICANT'S RESPONSIBILITY.

Signature ______ Date ______

PROVIDE YOUR VALID EMAIL ADDRESS HERE

______

5 ADDRESS & NAME CHANGE INFORMATION

Last ______ First ______ Middle Initial ______
Address ______ City ______ Province ______ Postal Code ______
Email ______ Home Phone ______ Cell Phone ______

6 ADDITIONAL EDUCATION

Please indicate if you obtained a diploma or a degree in NON-LPN NURSING or in a field OTHER THAN NURSING in the PAST 12 MONTHS.

(Select One Code)
01 Diploma/Certificate
02 Bachelor's Degree
03 Master's Degree
04 Doctorate
05 None

☐ Other than Nursing
Details: ______

(Select One Code)
01 Diploma/Certificate
02 Bachelor's Degree
03 Master's Degree
04 Doctorate
05 None

☐ Non-LPN Nursing
Details: ______

7 REGISTRATION WITH OTHER PROFESSIONAL ORGANIZATIONS

☐ College of Registered Nurses of BC
☐ College of Registered Psychiatric Nurses of BC
☐ Other (specify) ______
☐ Licensed Practical Nurses Association of BC
☐ I give my consent to have my name added to any nursing related mailing list in order to receive or participate in surveys, reports, etc.

AVOID DELAY RENEW BY DECEMBER 1, 2009
INCOMPLETE OR UNSIGNED FORMS WILL BE RETURNED.

8 CURRENT EMPLOYER(S) INFORMATION

STATUS Refers to Full-Time-Employed on a regular basis for a minimum of 37.5 hours/week; Part-Time-Employed on a regular basis for less than 37.5 hours/week; Casual-Not usually employed on a regular basis. ☑

Name of Employer(s) Facility/Institution/Agency	Health Authority	Status
First Employer: Address: City / Prov: Postal Code:	☐ Vancouver Coastal ☐ Vancouver Island ☐ Fraser ☐ Interior ☐ Northern ☐ Provincial ☐ Not Applicable	☐ Full-T ☐ Part-T/Casual
Second Employer: Address: City / Prov: Postal Code:	☐ Vancouver Coastal ☐ Vancouver Island ☐ Fraser ☐ Interior ☐ Northern ☐ Provincial ☐ Not Applicable	☐ Full-T ☐ Part-T/Casual
Third Employer: Address: City / Prov: Postal Code:	☐ Vancouver Coastal ☐ Vancouver Island ☐ Fraser ☐ Interior ☐ Northern ☐ Provincial ☐ Not Applicable	☐ Full-T ☐ Part-T/Casual

9 CURRENT POSITION(S)

Please provide information that best describes your type of position for each employer.

(Select One Code) ______ First ______ Second ______ Third

06 LPN / Staff Nurse / Community Health Nurse
08 Instructor / Educator / Professor
12 Co-ordinator / Care Manager
13 LPN Specialty
11 Other (Specify) ______________

10 PRIMARY AREA(S) OF RESPONSIBILITY

Please provide the area where you currently work the most number of hours in the year, even though you may move from one unit to another. Your choice should correspond to each of your current employer(s) only.

(Select One Code) ______ First ______ Second ______ Third

DIRECT PATIENT CARE

01 Medical / Surgical
02 Mental Health / Psychiatric
03 Pediatrics
04 Maternity / Newborn
05 Geriatrics / Long Term Care
06 Critical / Intensive Care
07 Community Health
08 Ambulatory Care
09 Home Care

DIRECT PATIENT CARE (Con't.)

10 Occupational Health
11 Operating Room / Recovery Room
12 Emergency Care
13 Nursing in Several Clinical Areas
14 Oncology
15 Rehabilitation
16 Palliative Care
19 Other (Direct Care) ______________

ADMINISTRATION

21 Nursing Service
22 Nursing Education
29 Other (Administration) ______________

EDUCATION

31 Teaching - Students
32 Teaching - Employees
33 Teaching - Patients / Clients
39 Other (Education) ______________

RESEARCH

41 Research Only
49 Other (Research) ______________

11 CURRENT PLACE(S) OF WORK

Please provide type of facility / agency where you are employed.

(Select One Code) ______ First ______ Second ______ Third

01 Hospital (General / Maternal / Pediatric / Psychiatric)
02 Mental Health Centre
03 Nursing Stations (Outpost or Clinics)
04 Rehabilitation / Convalescent Centre
05 Nursing Home / Long Term Care
06 Home Care Agency
07 Community Health Centre
08 Business / Industrial Office
09 Private Nursing Agency / Private Duty
10 Self-Employed
11 Physician's Office / Family Practice Unit
12 Educational Institution
13 Association / Government
14 Other (Specify) ______________

12 EMPLOYMENT STATUS

Only check one, which is CURRENTLY applicable. ☑

☐ I am employed as an LPN
☐ I am NOT employed as an LPN (explain) ______________
☐ I am NOT employed and seeking employment in nursing
☐ I am retired
☐ I am employed in other than nursing and seeking employment in nursing
☐ I am on Long Term Disability

13 HAVE YOU COMPLETED AN APPROVED IMMUNIZATION COURSE?

☐ Yes ☐ No Date: ______ / ______ / ______ (DD / MM / YY)

Name of Course ______________

Location ______________

NOTE:

1. The CLPNBC does not accept faxed or photocopied registration forms. All registration forms must be original copies - no duplicate copies are accepted.
2. Before submitting this form carefully read and double check that the information provided is complete and accurate. Your form will be returned to you if it is incomplete, not dated, unsigned or if the credit card is declined resulting in a delay of renewal.

Failure to renew your registration by December 31st, 2009 means that you will be unable to practice as a "Licensed Practical Nurse" and your name will be removed from the LPN Public Registry.