



REGISTERED NURSE REGISTRATION & PRACTICE PERMIT 2010 APPLICATION FORM

For Former Members, Associate Members and Retired Members

Please read the following requirements for registration as an RN in Alberta before completing your application form. If you have any questions, please contact CARNA Registration at 780.451.0043 or 1.800.252.9392.

Requirements for registration as an RN in Alberta include:

1. Currency of practice
 - 1125 hours of RN practice within the past five years or
 - successful completion of a degree or nursing program satisfactory to the Registrar or
 - successful completion of a nursing refresher program satisfactory to CARNA Provincial Council
2. Meeting Continuing Competence Program (CCP) requirements. Information about the CCP is available on the CARNA website. Please ensure you review the information prior to completing your application to ensure you comply with the CCP requirements. **CCP requirements are mandatory for RN registration in Alberta.**

For members who have held registration outside Alberta since they were last registered in Alberta:

3. If you have practiced outside Alberta since you last held registration in Alberta, you will be required to provide verification of your registration from each jurisdiction in which you held registration in the past five years. This application package includes a *Verification of Nurse Registration* form; please complete Part A and forward the form to the appropriate regulatory body. The verification must be sent to CARNA directly from the regulatory body.
 - If you practiced in any U.S. jurisdictions in the past five years, please list these jurisdictions on page 3 of the verification form, indicating if the jurisdiction provides online verification which includes discipline information. Online verification will be obtained by CARNA if it includes discipline information; if it does not, you must request an official verification from the jurisdiction.
4. Satisfactory employer reference from your current or most recent employer, if your practice was in Canada or the U.S. The reference must be on the form provided by CARNA, be based on a minimum of 225 hours of employment, and be signed by your immediate RN supervisor or manager. If you are unable to provide a reference from a Canadian or U.S. employer, based on a minimum of 225 hours, you may be issued a conditional practice permit. An *Employer Reference* form is included with this package.

Please note that on assessment of your application, you may be required to provide additional information or documentation, or you may be issued a conditional practice permit.



2010 APPLICATION FOR REGISTRATION & PRACTICE PERMIT FOR MEMBERS RETURNING TO PRACTICE

Oct. 1, 2009 – Sept. 30, 2010

1. Identification

Full legal name *Previous/other names (i.e. maiden name)*

Address(include apartment or suite number) *City*

Province/State/Territory *Country* *Postal code*

Home phone *Cell phone* *Home e-mail*

Birthdate _____ Female Male

day / month / year

For office use only

Received: _____

Reg.# _____

Approved: _____

Effective date: _____

2. Current Status

Returning from leave of absence

Returning from practice in another jurisdiction or country. Please indicate all jurisdictions in which you currently hold registration:

<i>Province /State / Country</i>	<i>Registration Number</i>	<i>Effective Date</i>	<i>Expiry Date</i>

Year last registered in Alberta: _____ Registration/Permit number: _____

3. Applicant Declaration

Are you currently the subject of an investigation, discipline hearing, or proceeding of any kind which could result in the encumbrance of your registration or license by a regulatory/licensing authority for nursing or any other occupation/profession in any province, territory, state or country? No Yes*

Since you last applied for registration with CARNA, have you:

a. pleaded guilty or been found guilty of a criminal offence for which you have not been pardoned? No Yes*

b. been denied registration or licensure by any regulatory body or jurisdiction? No Yes*

c. had your registration or license revoked, suspended, or encumbered in any way by any regulatory body or jurisdiction? No Yes*

Are you affected by a physical or mental condition or disorder that impairs your ability to practice nursing competently and safely? No Yes*

Are you affected by an addiction to alcohol, drugs or other chemicals that impairs your ability to practice nursing competently and safely? No Yes*

Have you ever contracted a blood borne virus infection, specifically hepatitis B virus infection, hepatitis C virus infection and/or human immunodeficiency virus (HIV) infection? No Yes*

***If you respond “yes”, you will be contacted by CARNA to submit any additional required documentation.**

4. Nursing Practice Hours (if returning from practice outside Alberta)

Membership Year	Registration status in Alberta	Registration status outside of Alberta	RN Practice Hours	Nurse Practitioner Practice Hours			Nursing Education Hours	Total Hours
				Family	Adult	Child		
Oct.1/09- Sept.30/10								
Oct. 1/08-Sept. 30/09								
Oct. 1/07-Sept. 30/08								
Oct. 1/06-Sept. 30/07								
Oct. 1/05-Sept. 30/06								
Oct. 1/04-Sept. 30/05								

5. Employment Status

The 2010 membership year is Oct. 1, 2009 to Sept. 30, 2010. Please indicate below your expected start date in Alberta. You must be registered with CARNA prior to practicing in Alberta. _____

6. Nursing Employment

Under legislation, practicing members must keep their employment information current. You can update information throughout the year online on your Member Profile. If you have additional employers to report, please attach a list .

- I have no employer at this time My employer information is reflected below

Primary employment

Name of facility/site:		
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual		
<i>Work setting</i>	<i>Area of responsibility</i>	<i>Position title</i>
<input type="checkbox"/> Hospital <input type="checkbox"/> Public Health <input type="checkbox"/> Community Health Agency <input type="checkbox"/> Education Institution <input type="checkbox"/> Private Nursing Agency <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Community Nursing Clinic <input type="checkbox"/> Physician/ Dentist/ Family Practice Unit <input type="checkbox"/> Mental Health Centre <input type="checkbox"/> Nursing Home/Long- term Care <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Business/ Industry/ Occupational Health <input type="checkbox"/> Association/ Govt/ Regional Office <input type="checkbox"/> Other (specify):	<input type="checkbox"/> General medical <input type="checkbox"/> General surgical <input type="checkbox"/> Pediatrics <input type="checkbox"/> Maternal/Newborn <input type="checkbox"/> Psychiatric/Mental Health <input type="checkbox"/> Oncology <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Home Care <input type="checkbox"/> Emergency/Prehospital <input type="checkbox"/> Community Health <input type="checkbox"/> Operating/Recovery Room <input type="checkbox"/> Perianesthesia <input type="checkbox"/> Public Health <input type="checkbox"/> Geriatric/Long-term Care <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Critical/Intensive Care <input type="checkbox"/> Telehealth <input type="checkbox"/> Occupational Health <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Several clinical areas	<input type="checkbox"/> Orthopedic <input type="checkbox"/> Nursing Education administration <input type="checkbox"/> Nursing Services administration <input type="checkbox"/> Other administration (specify): <input type="checkbox"/> Teaching students <input type="checkbox"/> Teaching employees <input type="checkbox"/> Teaching patients/clients <input type="checkbox"/> Other education (specify): <input type="checkbox"/> Clinical Nursing research <input type="checkbox"/> Other research (specify): <input type="checkbox"/> Other (specify):
		<input type="checkbox"/> Staff/Community Health Nurse <input type="checkbox"/> Director/Assistant Director <input type="checkbox"/> Consultant <input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Manager/Assistant Manager <input type="checkbox"/> Chief Nursing Officer/Chief Executive Officer <input type="checkbox"/> Instructor/Professor/Educator <input type="checkbox"/> Researcher (Principal or Co-Principal Investigator, Project Director, Clinical Research Nurse) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Family <input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Other (specify):

Other employment

Name of facility/site:			
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual			
Work setting	Area of responsibility	Position title	
<input type="checkbox"/> Hospital <input type="checkbox"/> Public Health <input type="checkbox"/> Community Health Agency <input type="checkbox"/> Education Institution <input type="checkbox"/> Private Nursing Agency <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Community Nursing Clinic <input type="checkbox"/> Physician/ Dentist/ Family Practice Unit <input type="checkbox"/> Mental Health Centre <input type="checkbox"/> Nursing Home/Long- term Care <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Business/ Industry/ Occupational Health <input type="checkbox"/> Association/ Govt/ Regional Office <input type="checkbox"/> Other (specify):	<input type="checkbox"/> General medical <input type="checkbox"/> General surgical <input type="checkbox"/> Pediatrics <input type="checkbox"/> Maternal/Newborn <input type="checkbox"/> Psychiatric/Mental Health <input type="checkbox"/> Oncology <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Home Care <input type="checkbox"/> Emergency/Prehospital <input type="checkbox"/> Community Health <input type="checkbox"/> Operating/Recovery Room <input type="checkbox"/> Perianesthesia <input type="checkbox"/> Public Health <input type="checkbox"/> Geriatric/Long-term Care <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Critical/Intensive Care <input type="checkbox"/> Telehealth <input type="checkbox"/> Occupational Health <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Several clinical areas	<input type="checkbox"/> Orthopedic <input type="checkbox"/> Nursing Education administration <input type="checkbox"/> Nursing Services administration <input type="checkbox"/> Other administration (specify): <input type="checkbox"/> Teaching students <input type="checkbox"/> Teaching employees <input type="checkbox"/> Teaching patients/clients <input type="checkbox"/> Other education (specify): <input type="checkbox"/> Clinical Nursing research <input type="checkbox"/> Other research (specify): <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Staff/Community Health Nurse <input type="checkbox"/> Director/Assistant Director <input type="checkbox"/> Consultant <input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Manager/Assistant Manager <input type="checkbox"/> Chief Nursing Officer/Chief Executive Officer <input type="checkbox"/> Instructor/Professor/Educator <input type="checkbox"/> Researcher (Principal or Co-Principal Investigator, Project Director, Clinical Research Nurse) <input type="checkbox"/> Nurse Practitioner <ul style="list-style-type: none"> <input type="checkbox"/> Family <input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Other (specify):

7. Continuing Competence: Reporting on the Completed Practice Year

If you did not complete reporting on your Continuing Competence indicators for the last year you practiced in Alberta, please complete the following section. Failure to report on your Continuing Competence indicators will result in an outstanding condition on your practice permit.

Indicator _____ Did you change this indicator during the year? Yes No If yes, changed to indicator: _____

Learning plan implemented

Yes No
 If no, check reason:
 Chose too many indicators
 Did not work as RN in Alberta
 Other _____

Learning goal met

Yes Partial No
 If no, check reason:
 Did not work in Alberta
 Other _____

This learning influenced my nursing practice

Yes No Unsure If yes how:
 Increased knowledge/skill/competence Enhanced accountability
 Enhanced critical thinking/decision making Increased confidence
 Developed program/process/product Improved work environment
 Other _____

Indicator _____ Did you change this indicator during the year? Yes No If yes, changed to indicator: _____

Learning plan implemented

Yes No
 If no, check reason:
 Chose too many indicators
 Did not work as RN in Alberta
 Other _____

Learning goal met

Yes Partial No
 If no, check reason:
 Did not work in Alberta
 Other _____

This learning influenced my nursing practice

Yes No Unsure If yes how:
 Increased knowledge/skill/competence Enhanced accountability
 Enhanced critical thinking/decision making Increased confidence
 Developed program/process/product Improved work environment
 Other _____

Indicator _____ Did you change this indicator during the year? Yes No If yes, changed to indicator: _____

Learning plan implemented

Yes No
 If no, check reason:
 Chose too many indicators
 Did not work as RN in Alberta
 Other _____

Learning goal met

Yes Partial No
 If no, check reason:
 Did not work in Alberta
 Other _____

This learning influenced my nursing practice

Yes No Unsure If yes how:
 Increased knowledge/skill/competence Enhanced accountability
 Enhanced critical thinking/decision making Increased confidence
 Developed program/process/product Improved work environment
 Other _____

8. Continuing Competence: Identify Indicators for the 2010 practice year

MANDATORY if you are applying for RN status **ANY TIME** between Oct. 1, 2009 and Sept. 30, 2010
A conditional practice permit will be issued if the required information is not provided.

- Complete a written assessment of your practice using the CARNA Nursing Practice Standards.
- Collect feedback about your practice.
- Prioritize a **minimum of one** and maximum of three indicator(s) for your professional development and record your indicators in the boxes below.

I have assessed my nursing practice, collected feedback, and initiated the development of a learning plan(s) for the following indicator(s):			
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- Throughout the practice year, develop and implement your learning plan for the indicator(s) you selected.

You do not need to submit your documents to CARNA unless requested. Keep your records for five years.

9. Consent to release personal information to approved third parties

Please indicate below whether you consent to the release by CARNA of your name, e-mail address, home address and home phone number to approved third parties for the following purposes:

- to participate in research relevant to nurses Yes No
- to receive information on professional and career opportunities Yes No
- to receive communication regarding membership benefits Yes No

10. Language Fluency

Please indicate any languages other than English or French in which you have complete fluency in reading, writing, speaking and comprehension such that you could provide safe, competent nursing in that language: _____

11. Fee Payment

Please check the option that applies to your current status

	<i>Registering on or before April 30, 2010</i>	<i>Registering on or after May 1, 2010</i>
Holding Associate or Retired membership with CARNA and not registered in another Canadian jurisdiction	\$430.50	\$274.58
Holding Associate or Retired membership with CARNA and registered for 2010 in another Canadian jurisdiction with membership in CNA*	\$374.02	\$218.10
Holding Former Member membership with CARNA and not registered in another Canadian jurisdiction	\$472.50	\$316.58
Holding Former Member membership with CARNA and registered for 2010 in another Canadian jurisdiction with membership in CNA*	416.02	\$260.10

* CNA membership fees are paid by regulatory bodies in all jurisdictions with the exception of OIIQ and CNO. Applicants from Ontario who are also members of RNAO pay CNA fees as part of their registration.

- Cheque (Cheque # _____) • Please make cheque or money order payable to CARNA.
- Direct debit (in person at the CARNA office) • A \$35 NSF charge will be levied for any cheque returned because of insufficient funds.
- VISA Mastercard • Registration fees are non-refundable. All fees include GST (Reg #R106692643)

_____ / _____ / _____ / _____ / _____ / _____ /	_____ / _____ / _____ / _____ / _____ / _____ /
Card number	Expiry date: month/year
_____ Name on card	_____ Signature

12. Verification

By signing this form, I certify that the information I have provided on this form is true and acknowledge that my registration may be refused, suspended or cancelled if I have provided any inaccurate information. I am hereby authorizing and consenting to the collection, use and disclosure of my personal information as described in the CARNA privacy policy.

This form cannot be processed if not signed and dated.

Signature _____ Date



VERIFICATION OF NURSE REGISTRATION

For members who have held registration outside Alberta since they were last registered in Alberta

Please complete the information on this page, sign the consent section and forward this form to each Regulatory/Licensing Authority with which you held registration in the past five years.

- If you practiced in any U.S., jurisdictions in the past five years, please list these U.S. jurisdictions on page 3 of this form, indicating if the jurisdiction provides online verification which includes discipline information. Online verification will be obtained by CARNA if it includes discipline information; if it does not, you must request an official verification from the jurisdiction.

Name _____
Last name *Given names* *Maiden Name (if applicable)*

Previous name(s) if applicable _____

Address _____
Apt *Street* *City / State* *Country*

Postal Code _____ Phone Home () _____

School of Nursing

City/Province/Country

Graduation Date ____/____/____
Day Month Year

Initial Registration Date ____/____/____
Day Month Year

Registration Number _____

Birthdate ____/____/____
Day Month Year

Consent

I hereby give consent for completion of this *Verification of Nurse Registration* form concerning my registered nurse status.

Signature of Applicant

Date

Instructions for Regulatory/Licensing Authority are on reverse

VERIFICATION OF NURSE REGISTRATION

Instructions for Regulatory/Licensing Authority

- Please provide the registration information below as requested by the applicant.
- The envelope must clearly show that the verification was mailed from the Registration/Licensing Authority directly to the College & Association of Registered Nurses of Alberta.

This will certify that _____
Last name
Given names
Previous name(s) if applicable

Birthdate _____ / _____ / _____ completed a nursing education program on _____ / _____ / _____
Day Month Year
Day Month Year

from _____
School of Nursing

_____ City / Province / Country

and was registered to practice as a _____ Registration Number _____

Initial Registration Date _____ / _____ / _____ Registration Expiry Date _____ / _____ / _____
Day Month Year
Day Month Year

Current status is: Registered Inactive Registration was by: Examination Endorsement

Is this person's registration/license currently revoked, suspended or under review? Yes* No

*If Yes, please attach documentation outlining action taken.

Name of examination written: _____ Was the examination was written in English? Yes No

CNA Testing Services

NLN State Board Test Pool Number of times examination written _____

NCLEX-RN

Other (specify) _____ Passing Score _____

Results achieved on examination:

Medical Nursing	Surgical Nursing	Obstetrical Nursing	Pediatric Nursing	Psychiatric Nursing	Comprehensive Exam	Criterion Referenced

Official Seal or Stamp

Signature
Print Name
Title

Name of Licensing Authority
Date

Please return directly to:
 College & Association of Registered Nurses of Alberta
 11620 - 168 Street, Edmonton, Alberta T5M 4A6
 780.451.0043 Toll free in Canada 1.800.252.9392 www.nurses.ab.ca



**VERIFICATION OF NURSE REGISTRATION
IN UNITED STATES OF AMERICA ONLY**

Applicant Instructions:

Please indicate below the names of any jurisdictions in the United States where you held registration in the past five years.

Name of Jurisdiction	Online verification is available and it includes discipline therefore I request CARNA obtain the online verification	On line verification is not available or does not include discipline, therefore I have requested the State Board of Nursing send official verification to CARNA
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes



Employer Reference

This reference must be based on a minimum of 225 hours of employment as a Graduate Nurse (GN) or Registered Nurse (RN) with one employer, within the past five years.

Instructions for Applicant

- Complete the personal information below
- Sign the consent section
- Forward this form to your immediate nursing employer, who will complete the second page and mail the form directly back to CARNA. Reference forms are not to be returned by the applicant.

Full Legal Name _____
Last Name First and Middle Name Name Before Marriage (if applicable)

Previous Names (if applicable): _____

Address _____
Apt Street City Province/State

Postal Code Phone () Birthdate / /
Day Month Year

Consent

I hereby give consent to my present or past employer to fully complete the employer portion of this form, concerning my competency to practice nursing, for the purpose of assessing my eligibility for registration and a practice permit in Alberta.

Signature of Applicant

Date

Employer instructions on reverse

Employer Reference

Required for the purpose of determining eligibility for a CARNA practice permit

Instructions for Employer

- The reference must be based on a minimum of **225** hours of nursing practice.
- **The reference must come from an RN if possible. If this is not possible, please include manager's designation.**
- **Please complete all questions. If you are not able to complete this reference, please notify the applicant.**
- Applicant may be made aware of the information on this reference.
- Return the reference directly to the College & Association of Registered Nurses of Alberta (CARNA). The envelope must clearly identify that the reference was mailed by the employer.

Employee _____ was employed by _____
Last name Given name(s) Other/previous name(s) if applicable

Employer _____
Provide complete name of employer

Address _____ Phone [] _____
City Province/State

Employed as: GN RN Start Date: (day/mo/yr) ____/____/____ End Date: (day/mo/yr) ____/____/____
Still employed: Yes No Applicant in good standing with organization: Yes No
Total hours worked (not less than 225 hours) _____ (Hours from a Nursing Refresher Program cannot be counted in the total.)

The above named applicant has met the competency requirements as follows:

I verify that this person practices safely, according to the CARNA Nursing Practice Standards, as listed below:

1. The applicant is personally responsible and accountable for ensuring that her/his nursing practice and conduct meet the standards of the profession and legislative requirements. Yes No UTV*
2. The applicant continually strives to acquire knowledge and skills to provide competent, evidence-based nursing practice. Yes No UTV*
3. The applicant complies with the Canadian Nurses Association's *Code of Ethics for Registered Nurses* (2008). Yes No UTV*
4. The applicant provides nursing service in collaboration with the client, significant others, and other health professionals. Yes No UTV*
5. Do you recommend this individual for a nursing practice permit? Yes No

If recommending this individual for a nursing practice permit, you are attesting to his/her professional competence and good character.

*Unable to verify – please give reason(s) below if you respond “No” or “UTV”:

Signature

Print Full Name

Title / Position with above named employer

Registration # Date

Email

Current Phone Number

Completed form must be mailed to CARNA directly from the employer. Thank you.