

## 2010 COURTESY PERMIT APPLICATION FORM

### For Applicants who are currently registered as an RN in a Canadian jurisdiction outside Alberta

Courtesy permits are granted under certain circumstances to allow RNs from other jurisdictions to practice nursing in Alberta for a specific purpose on a short-term basis, not to exceed one year. Courtesy permit holders are required to maintain RN registration in good standing in their home jurisdiction throughout the period of the Courtesy permit.

Please read the following requirements for registration as an RN 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. Verification of registration with the Canadian province or territory in which you currently hold registration. A *Verification of Nurse Registration* form is included with this package. Please complete Part A and forward the form to your regulatory body. The verification must be sent to CARNA directly from the regulatory body.
3. Identification: a photocopy of your birth certificate, one piece of photo identification and a copy of any name change documents (e.g. marriage certificate) if applicable. Your complete legal name and birth date must show on your identification and must be consistent on all identification provided.
4. Proof of fluency in English. If your first language\* is not English you are required to provide proof of fluency in speaking, writing and comprehension of the English language. A list of acceptable English fluency tests and the accepted achievement level for each is available on the CARNA website. Official English language test scores must be sent to CARNA directly from the testing service, and cannot be more than two years old.

\* English can only be considered your first language if:

- it is the language you learned at home in childhood **or**
- it is the language which you identify as knowing best and being most comfortable with **and** it is the language you primarily use for reading, writing, listening, and speaking

**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 COURTESY PERMIT APPLICATION FORM

Oct. 1, 2009 – Sept. 30, 2010

<p><b>1. Identification</b></p> <p>_____</p> <p><i>Full legal name</i> <span style="float: right;"><i>Previous/other names (i.e. maiden name)</i></span></p> <hr/> <p>_____</p> <p><i>Address (include apartment/suite number)</i> <span style="float: right;"><i>City</i></span></p> <hr/> <p>_____</p> <p><i>Province/State/Territory</i> <span style="margin-left: 100px;"><i>Country</i></span> <span style="float: right;"><i>Postal code</i></span></p> <hr/> <p>_____</p> <p><i>Home phone</i> <span style="margin-left: 100px;"><i>Cell phone</i></span> <span style="float: right;"><i>Home e-mail</i></span></p> <hr/> <p>Birthdate _____ <span style="margin-left: 100px;"><input type="checkbox"/> Female <input type="checkbox"/> Male</span></p> <p style="margin-left: 20px;"><i>day / month / year</i></p>	<p style="text-align: center;"><b>For office use only</b></p> <p>Received: _____</p> <p>Stakeholder# _____</p> <p>Approved _____</p> <p>Permit# _____</p> <p>Effective date: _____</p>
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**Please notify CARNA immediately of any changes to your contact information by updating your Member Profile on the CARNA website: [www.nurses.ab.ca](http://www.nurses.ab.ca)**

<p><b>2. Requested Status</b>      <input type="checkbox"/> Courtesy RN      <input type="checkbox"/> Courtesy NP</p> <p><b>Requested Permit Dates</b>    Start: _____    End: _____</p> <p><b>Reason for requesting a courtesy permit</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<b>3. Please indicate all jurisdictions in which you currently hold registration</b>			
<i>Province /State / Country</i>	<i>Registration Number</i>	<i>Effective Date</i>	<i>Expiry Date</i>

**4. 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\*

Have you ever:

- 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.**

**5. Consent to release personal information to approved third parties**

As a member of CARNA, you automatically become a member of the Canadian Nurses Association (CNA) and your name and home address are provided to CNA. CARNA also receives requests from third parties for access to members’ personal information. 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

*You may remove your consent by notifying CARNA or by updating your Member Profile on the CARNA website.*

**6. Language Declaration**

My first language is:  English  French  Other (specify): \_\_\_\_\_

Please indicate any **other** languages in which you have complete fluency in reading, writing, speaking and comprehension such that you could provide safe, competent nursing in that language: \_\_\_\_\_

**7. Nursing Practice Hours**

Hours must be reported according to the CARNA membership year, which is October 1 to September 30. You may report nursing practice hours from nursing employment anywhere in the world where you were registered as a Registered Nurse, Graduate Nurse or Nurse Practitioner during the last five years. Do not include vacation, LOA, or sick time. Do **not** send a resume.

Dates of Employment	Employer Name / Address / Province / State / Country	Number of Hours Worked (provide actual hours)
Oct 1, 2009 - Sept 30, 2010		
Oct 1, 2008 - Sept 30, 2009		
Oct 1, 2007 - Sept 30, 2008		
Oct 1, 2006 - Sept 30, 2007		
Oct 1, 2005 - Sept 30, 2006		
Oct 1, 2004 - Sept 30, 2005		

## 8. 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 to this form.

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

### Primary employment

<b>Name of facility/site:</b>			
<input type="checkbox"/> <b>Full-time</b> <input type="checkbox"/> <b>Part-time</b> <input type="checkbox"/> <b>Casual</b>			
<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 <ul style="list-style-type: none"> <li><input type="checkbox"/> Family</li> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Child</li> </ul> <input type="checkbox"/> Other (specify):

### Other employment

<b>Name of facility/site:</b>			
<input type="checkbox"/> <b>Full-time</b> <input type="checkbox"/> <b>Part-time</b> <input type="checkbox"/> <b>Casual</b>			
<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 <ul style="list-style-type: none"> <li><input type="checkbox"/> Family</li> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Child</li> </ul> <input type="checkbox"/> Other (specify):





# Verification of Nurse Registration

11620 - 168 Street, Edmonton, Alberta T5M 4A6 Telephone (780) 451-0043  
Toll Free in Canada 1-800-252-9392 Website [www.nurses.ab.ca](http://www.nurses.ab.ca) e-mail [carna@nurses.ab.ca](mailto:carna@nurses.ab.ca)

## Applicant Instructions

Complete the personal information, sign the consent section and forward this form to the Regulatory/Licensing Authority for the jurisdiction in which you most recently held registration.

Name \_\_\_\_\_  
*Last name* *Given name(s)* *Other name(s) 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*

Registration Date \_\_\_\_\_  
*Day* *Month* *Year*

Registration Number \_\_\_\_\_

Birthdate \_\_\_\_\_  
*Day* *Month* *Year*

## Consent

I hereby give consent for completion of this verification form concerning my registration as a Registered Nurse.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

*Instructions for Regulatory/Licensing Authority are on reverse*

# Verification of Nurse Registration

## Regulatory/Licensing Authority Instructions

- Please provide the information below as requested by the applicant and return the completed form to:  
**College & Association of Registered Nurses of Alberta**  
**11620 – 168 Street, Edmonton, Alberta T5M 4A6**
- The envelope must clearly show that the verification was mailed from the Regulatory/Licensing Authority directly to CARNA.

This will certify that \_\_\_\_\_  
Last name Given name(s) Other name(s) if applicable

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ completed an approved nursing education program on \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year Day Month Year

from \_\_\_\_\_  
School of Nursing

\_\_\_\_\_ City / Province / Country

and was registered to practice as \_\_\_\_\_ 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 written in English  Yes  No

CNA Testing Services

NLN State Board Test Pool

NCLEX-RN

Other(specify) \_\_\_\_\_

Number of times examination written \_\_\_\_\_

Passing Score \_\_\_\_\_

**Place  
Official  
Seal or  
Stamp  
Here**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name of Regulatory/Licensing Authority

\_\_\_\_\_  
Contact phone number

\_\_\_\_\_  
Date