College of Licensed Practical Nurses
of British Columbia

260 – 3480 Gilmore Way
Burnaby BC V5G 4Y1
Tel: 778 373 3100
Fax: 778 373 3102
Toll Free in BC: 1.877.373.2201
Email: info@clpnbc.org
www.clpnbc.org

ensuring safe, competent and ethical nursing practice

Nursing Program Confirmation

PART A: To be completed by applicant and sent to each School of Nursing where courses completed.

Name of Applicant:	
Former Name(s):	
Date of Birth:	Date of Graduation:
Address:	
Name and Address of School where nursing program completed:	
Signature:	Date:

PART B: To be completed by the Dean/Coordinator of Health Sciences and returned directly <u>with an official transcript</u> of nursing education to the College of Licensed Practical Nurses of British Columbia.

The applicant was admitted to the Nursing Program above. ☐ yes ☐ no

He/she graduated on the date stated. ☐ yes ☐ no

If no, what portion of the program was completed?_________ months.
The total hours spent in theory is____________.
The total hours spent in clinical is____________.
The complete program is a total of __________ months.

Please indicate the number of hours the applicant completed in theory and clinical practice in each area, and if there was a lab completed:

Area:	Theory Hours:	Clinical Hours:	Lab: (yes or no)
Medical			
Surgical			
Maternal/Newborn			
Pediatrics (Children’s)			
Community/Mental Health/Psychiatric			
Gerontology			

Please Turn Over →

Please indicate with a checkmark if the following competencies were included in the applicant's nursing program:

Competency:	Theory:	Clinical:	Lab:
Surgical Asepsis Eg. Catheters/dressings	☐	☐	☐
Physical Assessments including auscultation and percussion	☐	☐	☐
Pharmacology	☐	☐	☐
Subcutaneous Injections	☐	☐	☐
Intramuscular & Narcotic Administration	☐	☐	☐
Supporting Intravenous Therapy & Blood Products	☐	☐	☐
Taking and Transcribing Medication Orders	☐		

Confidential Comments:

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_________________________ _________________________

Signature Title

_________________________ _________________________

Name (please print) Date

____

Telephone Number