Phone: 1.306.525.1436
Toll Free: 1.888.257.2576
Fax: 1.306.347.7784

Saskatchewan Association of Licensed Practical Nurses
2208 E Victoria Avenue ~ Regina, SK S4N 7B9

SALPN Out of Province Graduate Licensed Practical Nurse

APPLICATION FOR REGISTRATION

PERSONAL (Please Print)

Current Legal Surname (Last Name) _____

Given Name (First Name) _____

Middle Name(s) _____

Maiden Name _____

Date of Birth (dd/mm/yy) _____

Sex ❒ Female ❒ Male

Apartment / Box No. / Address or Street No. _____

City / Town / Village _____

Province/State _____

Country _____

Postal Code / Zip Code _____

Telephone No. _____

Cell No. _____

Alternate _____

E-mail Address (MANDATORY) _____

PERSONAL DECLARATION (check all applicable)

1. Have you ever applied for registration/licensure in Saskatchewan previously? ❒Yes ❒No
2. Have you applied for registration/licensure in any Canadian province or territory? ❒Yes ❒No
3. Have you ever been denied registration/licensure by a registration/ licensing authority for nursing in Saskatchewan or any other health profession in Saskatchewan or any other province, territory, state or country (excluding SALPN)? ❒Yes ❒No
4. Have you ever been subject to any investigative proceedings with respect to unprofessional conduct, incompetence, or incapacity in nursing by any regulatory body, in Saskatchewan or any other province, territory, state or country (excluding SALPN)? ❒Yes ❒No
5. Are you currently under investigation or involved in any proceedings, which could or has resulted in the encumbrance of your nursing registration by:
   a. A registration/licensing authority for nursing LPN/RPN/RN in any province, territory, state or country? ❒Yes ❒No
   b. Another health profession (other than nursing) in any province, territory, state or country? ❒Yes ❒No
   c. Any other profession in any province, territory, state or country? ❒Yes ❒No
6. Have you been charged with or convicted of a criminal offense? If yes, please explain and attach an updated Criminal Record Check (original copy) ❒Yes ❒No
7. Have you pleaded guilty or been found guilty of a criminal offence for which a pardon has been granted? ❒Yes ❒No

8. Do you have any physical or mental condition or disorder that may impair your ability to provide safe, competent and ethical care? **If you have answered yes to question 8, answer the questions below; otherwise leave questions (a) and (b) blank.** ❒Yes ❒No
   a. If "Yes", are you under the care of a physician or healthcare team? ❒Yes ❒No
   b. If "Yes", are you following medical advice? ❒Yes ❒No

If any circumstances change throughout the year, you are required to contact SALPN.

9. Is the English language your first learned language and is it the language you first learned and understood in childhood for reading, writing, listening, and speaking. ❒Yes ❒No
   (if no, one of the following will be accepted:
   1. **IELTS test results**
   2. **Evidence of completing a Canadian Practical Nursing program in English plus an additional two (2) years of full time study in English in Canada. Full time study is defined as a minimum of three (3) classes per semester.**
   3. **Evidence of completing four (4) years of full time study in English in Canada must be provided. Full time study is defined as a minimum of three (3) classes per semester.**

(Please Print: With the exception to #9, if you answered 'YES' to any question on the Personal Declaration, provide a brief explanation, add a separate piece of paper if needed)

NURSING EDUCATION (Please Print: Provide all nursing programs taken, including both basic and re-entry programs.)

Name of Nursing Program		Start Date (dd/mm/yy)	Completion Date (dd/mm/yy)	Credential Received (example; Degree, Diploma, Certificate)
Name of Educational Institution & Campus				

CANADIAN PRACTICAL NURSE REGISTRATION EXAMINATION (CPNRE)

Number of Times Examination Written	Passed · Yes · No

ADDITIONAL EDUCATION (Please Print: Report all post basic programs and/or courses completed. If more than 3, please provide on a separate piece of paper.)

Name of Credential Received	Institution Name and Country	Start Date and Completion Date
Name of Credential Received	Institution Name and Country	Start Date and Completion Date
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INITIAL NURSING REGISTRATION (Please Print: Provide original registration information only, even if registration is no longer current) *Please leave blank if not applicable*

Registration or Licensure Type (LPN, RN)	Registration or Licensure Status	Conditions/Limitations on Registration or Licensure (if applicable)	Province/State/ Country	Registration Licensure Number	Issued Date (dd/mm/yy)	Expiry Date (dd/mm/yy)

CURRENT/PAST NURSING REGISTRATION/LICENSURE (Provide all places of registration (other than with SALPN) or other regulated profession(s) (i.e. registered nurse, physiotherapist, midwife, paramedic, etc.). If you are not currently registered, then provide the most recent place of registration/licensure. If more than 2, please provide on a separate piece of paper. ***Please leave blank if not applicable***

Registration or Licensure Type (LPN, RN)	Registration or Licensure Status	Conditions/Limitations on Registration or Licensure (if applicable)	Province/State/ Country	Registration or Licensure Number	Issued Date (dd/mm/yy)	Expiry Date (dd/mm/yy)

NURSING EMPLOYMENT (Please Print: Provide employment information if a practical nursing position has been secured upon licensure)

Employer Name and Phone

Job Title/Position	Address	Unit/Area of Responsibility (check applicable boxes) ❒Medical ❒Mental Health/Psychiatry ❒Surgical ❒Community ❒Obstetrics Care ❒Gerontology/Long Term Care ❒Pediatrics ❒Other_____
Start Date (dd/mm/yy)	Status (Full-Time, Part-Time, Casual)	
Employer Name and Phone	End date (dd/mm/yy)	
Job Title/Position	Address	Unit/Area of Responsibility (check applicable boxes) ❒Medical ❒Mental Health/Psychiatry ❒Surgical ❒Community ❒Obstetrics Care ❒Gerontology/Long Term Care ❒Pediatrics ❒Other_____
Start Date (dd/mm/yy)	Status (Full-Time, Part-Time, Casual)	
Employer Name and Phone	End date (dd/mm/yy)	
Job Title/Position	Address	Unit/Area of Responsibility (check applicable boxes)

Start Date (dd/mm/yy)	Status (Full-Time, Part-Time, Casual)	❒Medical ❒Mental Health/Psychiatry ❒Surgical ❒Community ❒Obstetrics Care ❒Gerontology/Long Term Care ❒Pediatrics ❒Other_____
Employer Name and Phone	End date (dd/mm/yy)	

NURSING EMPLOYMENT HISTORY (Please Print: Provide all employment in the past 5 years, if more than 1, please provide on a separate sheet of paper.) *Please leave blank if not applicable*

Employer Name and Phone		End date (dd/mm/yy)
Job Title/Position	Address	Unit/Area of Responsibility (check applicable boxes) ❒Medical ❒Mental Health/Psychiatry ❒Surgical ❒Community ❒Obstetrics Care ❒Gerontology/Long Term Care ❒Pediatrics ❒Other_____
Start Date (dd/mm/yy)	Status (Full-Time, Part-Time, Casual)	

ADDITIONAL APPLICATION REQUIREMENTS (You must also submit the following with your application form or it may be considered incomplete, please verify.)

❒ I have included a clear copy of my birth certificate, marriage certificate and/or valid passport. (Mail or Email; Do Not Fax)

❒ I have included $905.00 for the non-refundable application fee, CPNRE fee, and GLPN licensure fee. (Visa/MasterCard payable on the credit card authorization form, cheque, certified cheque or money order payable to SALPN. Please do not mail cash.

PRIVACY STATEMENT

I acknowledge that the information contained in this form is being collected and will be used for the purpose of assessing my application for licensure. This information will be maintained on my file and may also be used to assess my application for renewal of my practicing renewal in the future or for the purpose of a discipline proceeding under the LPN Act, 2000. The information contained in this form will only be disclosed pursuant to the provisions in the *LPN Act, 2000,* the *Personal Information Protection Act,* as otherwise required by law, unless your consent to disclose the information has been obtained.

CONSENT TO REVOCATION/SUSPENSION OF LICENSURE

I acknowledge and agree that the SALPN may, at its option, immediately revoke, suspend or refuse to renew my licensure if any information contained in this application is inaccurate or incomplete until such that the SALPN has had the opportunity to reconsider my application. I agree to provide any additional information that may be required by the SALPN to consider my application for licensure. I agree to return my licensure to the SALPN as requested in the event that my licensure is revoked or suspended. I also acknowledge and agree that I may be subject to disciplinary action, irrespective of whether my licensure is revoked or suspended with the SALPN, if I fail to provide current, correct and complete information to the SALPN in respect to my application for licensure.

LICENSURE DECLARATION

I declare that all of the information on this form is current, correct and complete. I declare that all documents submitted with this application to the SALPN are authentic true originals or true copies of original documents. I declare that I am of good character and am fit to practice, consistent with the responsibilities, ethics and standards expected of a Licensed Practical Nurse. I hereby certify that I am the person making application for licensure as a Licensed Practical Nurse in Saskatchewan and that all statements are true and complete in every respect. I understand that omission, inaccuracy, and falsification of information on this application may result in the cancellation of my application for licensure or cancellation of any licensure, which may be issued. I understand that my application for assessment of eligibility and/or licensure is considered lapsed if required documentation is not received in the SALPN office and I have not obtained licensure within 6 months from my application date. I understand that after 6 months have lapsed I am required to reapply.

_____ Applicant Signature (do not print)	_____ Date (dd/mm/yy)

Saskatchewan Association of Licensed Practical Nurses salpn

SALPN GLPN & CPNRE Fees

CREDIT CARD AUTHORIZATION FORM

PAYMENT INFORMATION (please print)			
Date:		**AMOUNT DUE:**	**$905.00**
Payment Description:	❑ **Application Fee - $100.00** **DUE IMMEDIATELY** ❑ **CPNRE Fee - $405.00** **DUE IMMEDIATELY** ❑ **Licensure Fee - $400.00** **AT DISCRETION OF APPLICANT**		

PERSONAL INFORMATION (please print)					
Name:					
Address:					
City:		Province:		Postal Code:	
Phone:		Cell:			
Email:					

CREDIT CARD INFORMATION (please print)			
Cardholder Name:			
Credit Card #:			
Expiry Date:	Month:	Year:	❑VISA ❑MasterCard