

Application for Certified Practice Registration — Course/Exit Evaluation Completed

You will be notified by email when registration for certified practice has been granted.

Last name: _____ First name: _____

Middle name: _____ Former name(s) if applicable: _____

Date of birth (mm/dd/yy): _____ BCCNM ID: _____

Address (Apt/Box/#/Street): _____ City/town: _____

Province/State: _____ Country: _____ Postal code/zip code: _____

PART A

| | |
|--|--|
| I am applying for BCCNM-certified practice in: | <input type="checkbox"/> RN First Call |
| | <input type="checkbox"/> Reproductive Health (STI) |
| | <input type="checkbox"/> Reproductive Health (CM) |

OR

| | |
|---------------------------------------|--|
| I am applying for Remote Nursing and: | <input type="radio"/> I have completed the Reproductive Health courses |
| | <input type="radio"/> I have NOT completed the Reproductive Health courses |

PART B

| | |
|---|---|
| I am a registered as an RN and/or Nurse Practitioner (Paediatric/Adult) and have: | <input type="radio"/> Completed a BCCNM-approved (formerly CRNBC-approved) Certified Practice Education Program |
| | <input type="radio"/> Certified Practice Experience in another Canadian jurisdiction |

OR

| | |
|--|--|
| I am registered as a Nurse Practitioner (Family with BCCNM) and: | <input type="radio"/> I have successfully completed the ANCC (or equivalent) and BCCNM (formerly CRNBC) OSCE |
| | <input type="radio"/> I have not completed the ANCC (or equivalent) and the BCCNM (formerly CRNBC) OSCE |

PART C (required only if you completed a BCCNM-recognized education program)

| | | | |
|---|-----------------------------|----------------------------|----------------------------|
| Where did you complete your Certified Practice Program/Exit Evaluation? | <input type="radio"/> BCDDC | <input type="radio"/> BCIT | <input type="radio"/> UNBC |
| Date you completed course: _____ | | | |

PART C (required only if you completed a BCCNM-recognized education program) (Cont'd)

CONSENT TO RELEASE INFORMATION: I hereby provide consent for the above named certified practice program to release information and my course results to BCCNM. This information is to be used solely for the purpose of assessing my application for certified practice registration.

DECLARATION: I declare that I have assessed my practice based on the competencies and decision support tools for the category of certified practice for which I am applying. Based on my assessment, my practice is safe, competent and ethical and is within the scope identified by the decision support tools. I hereby apply for certified practice registration in BCCNM and I certify that the information provided on this form is true and correct and that I am in compliance with the Health Professions Act, Nurses (Registered) and Nurse Practitioners Regulation and BCCNM Bylaws.

I acknowledge that my name, registration number, status (practising, non-practising) and certified practice category will be published on the BCCNM website, in accordance with Section 22 of the Health Professions Act, upon being granted registration. BCCNM's register, which includes information about each registrant as required in Section 21.2 of the Health Professions Act, is available to any person upon request. To ensure appropriate and timely access to information about its registrants, BCCNM provides this information on its website, which is readily available to the public and other healthcare professionals.

Date: _____

You must print this form and send to BCCNM Registration Services:

Fax 604.899.0794

Email register@bccnm.ca

For office use:

Program Completion Confirmation: Yes / No

Has Current RN Practising: Yes / No

Employer Reference Required: Yes / No

Permission to challenge exam directly required: Yes / No

Date Certified Practice granted: _____