British Columbia College of Nurses & Midwives

900 – 200 Granville St.
Vancouver, BC
Canada V6C 1S4

Tel: 604.742.6200
Toll-free: 1.866.880.7101
Fax: 604.899.0794
Email: register@bccnm.ca
www.bccnm.ca

Form 71.1

Employer Reference – Remote Certified Practice Competencies

This form is used to assess an applicant's eligibility for certified practice registration in British Columbia. It must be completed by both the applicant for certified practice registration and the applicant's recent employer (within the past year).

Applicant: Complete Part A and then forward this form to your Canadian employer to complete Part B (you can save and email the form to your employer to complete electronically), if you have practised in the past year in this area.

Employer: Complete Part B and submit this form to BCCNM via email or regular mail.

Use Acrobat Reader to enter the information in the spaces provided or print the form and fill it in by hand.

Part A: To be completed by applicant, and sent to previous employer to complete Part B

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: _____

Email: _____ Tel: _____

Date: _____

My practice included all areas of this Certified Practice area in the past year: ◯ YES ◯ NO

Part B: Employer to complete this section and send completed Form 71.1 to BCCNM

If mailing, please use an official envelope or sign over seal. If faxing, please attach an official envelope or sign over seal. If faxing, please attach an official cover sheet.

Employer: _____

Applicant employed from (month/year): _____ to (month/year): _____

Was this a registered nurse position? ◯ YES ◯ NO

Please verify that the applicant named in this application has, in the past year, practised the competencies to independently assess, diagnose and treat the following remote health practices:

		Satisfactory	Unsatisfactory	Not known/ Not Applicable
Genitourinary	Lower UTI (adult and pediatric)	◯	◯	◯
Eye	Conjunctivitis (adult and pediatric), corneal abrasion (adult and pediatric)	◯	◯	◯
Ears-Nose-Throat	Acute otitis media (adult and pediatric), ceruminosis (adult), dental abscess (adult), and pharyngitis (adult)	◯	◯	◯
Respiratory	Acute bronchitis (adult)	◯	◯	◯

Part B: Employer to complete this section and send completed Form 71.1 to BCCNM (Cont'd)

		Satisfactory	Unsatisfactory	Not known/ Not Applicable
Skin	Localized abscess and furuncle (adult), cellulitis (adult and pediatric), impetigo (adult and pediatric), and bites (adult and pediatric)	◯	◯	◯
Pain Management	Use of nitrous oxide to manage pain (adult)	◯	◯	◯

Employer's comments (optional):

_____

_____

More Information

Name of person completing this form: _____

Title/Position: _____

Signature: _____ Date (mm/dd/yy): _____

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

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

Email: _____ Telephone: _____

Employer: If submitting by email, save completed form to your desktop and attach it to your to email.

If mailing, please use a corporate envelope or sign over the seal. If faxing, please use a corporate cover page.

BCCNM Registration Services
900-200 Granville Street
Vancouver, BC
Canada V6C 1S4
register@bccnm.ca
Fax 604.899.0794