British Columbia College of Nurses & Midwives

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Form 71.2

Employer Reference – Reproductive Health 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 or mail or fax it directly to BCCNM.

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

Name: _____

BCCNM ID (N/A if you do not have a BCCNM ID): _____

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

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

Email: _____ Tel: _____

Date: _____

I am applying for BCCNM-certified practice in: ☐ Sexually Transmitted Infections ☐ Contraceptive Management

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 71.2 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 (STIs and Contraceptive Management) to independently assess, diagnose and treat the following reproductive health practices:

		Satisfactory	Unsatisfactory	Not known/ Not Applicable
Contraceptive Management	Combined hormonal contraception, progestin-only contraception	◯	◯	◯
Sexually Transmitted Infections (STI)	Bacterial vaginosis, chlamydia trachomatis, genital warts, lower urinary tract infection (female), mucopurulent cervicitis, gonorrhea, recurrent urethritis (male), trichomoniasis, urethritis (male)	◯	◯	◯

Part B: Employer to complete this section and send completed Form 71.2 to BCCNM (Cont'd)

Employer's comments (optional):

_____

_____

More Information

Name of person completing this form: _____

Title/Position: _____

Signature (required only if returning by mail or fax): _____ Date: _____

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
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