BCCN&M British Columbia College of Nurses & Midwives

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**Form 71.3**

# Employer Reference – RN First Call 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 reg no. (N/A if you do not have a BCCNM No.): ______________________________

Address (apt/box no.): __________ Number: __________ Street: ______________________________

City/town: ______________ Province/state/country: __________ Postal/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 71.3 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 RN First Call health practices:

| | | Satisfactory | Unsatisfactory | Not known/ Not Applicable |
|---|---|---|---|---|
| Eye | Conjunctivitis (adult and pediatric), corneal abrasion (adult and pediatric) | ○ | ○ | ○ |
| Ear-Nose-Throat | Acute otitis media (adult and pediatric), dental abscess (adult), pharyngitis (adult and pediatric) | ○ | ○ | ○ |
| Respiratory | Acute bronchitis (adult) | ○ | ○ | ○ |
| Urinary Tract | Lower UTI – Female (adult) | ○ | ○ | ○ |

## Part B: Employer to complete this section and send completed Form 71.3 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 of employer (number): ____________ (Street) ____________ (City/town)______________________________

(Province/state/country)_______________________________________ (Postal/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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