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

Nurse Practitioner Application Package: NPs Educated & Registered Outside Canada

For use by nurse practitioners educated and registered outside of Canada

Instructions

Please complete the following forms and submit them to BCCNM at register@bccnm.ca:

- Form 6: Application for Nurse Practitioner Registration in British Columbia
- Form 8.1A: Application for Provisional Registration (confirm eligibility before submitting)
- Form 21: Application for the Nurse Practitioner Examinations
- Form 23: Professional Experience Record
- Form 33: Payment Form

Send the following forms to the appropriate organizations. **BCCNM must receive these forms directly from the issuing organization**:

- Form 17: Verification of Nurse Practitioner Registration
- Form 24: Request for Transcript
- Form 37: Nursing Employment Verification (for each nursing employer in the last five years)
- Form 39: Nurse Practitioner Program Information Request

Checklist

To ensure your application proceeds without delays, make sure you have included each item below in your application package or completed the following steps:

- ☐ Completed Form 6. Ensure you have answered all questions on all pages.
- ☐ Completed Form 8.1A only after your application has been assessed and you have been determined eligible for provisional registration. Do not submit the form until page 2 has bee completed and signed by your prospective employer. You can submit this form at any time before passing the required examinations.
- ☐ Completed Form 21.
- ☐ Completed Form 23.
- ☐ Completed Form 33.
- ☐ Certified passport photo. The passport photo must be mailed to BCCNM to use on your OSCE ID badge. Please ensure the photo has been certified by the photographer with your name clearly labelled on the back.
- ☐ Sent Form 17 to all jurisdictions in which you have been registered as a nurse practitioner.
- ☐ Sent Form 24 to all schools where you completed a nurse practitioner and master's education.
- ☐ Completed Parts A to C of Form 37 and sent to each nursing employer from the last five years.
- ☐ Completed Part A of Form 39 and sent to each educational institution from which you received credit for completed nurse practitioner courses.

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Application for Nurse Practitioner Registration

Instructions

- Complete all sections of this form; incomplete forms will cause delays to your application.

Part A — Personal information

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 B — Application type

I am applying for (check one):

☐ Nurse practitioner (Family) ☐ Nurse practitioner (Adult) ☐ Nurse practitioner (Pediatric)

Part C — Criminal record check

Have you ever been arrested for, or charged with, a criminal offence? ☐ No ☐ Yes

- If your answer is No, please proceed to section D
- If your answer is Yes, please answer questions below:

a) What was the reason for the arrest or charge?

_____

_____

b) What was the location and date of the arrest or charge?

_____

_____

c) How was this charge resolved or concluded, including any pardoned offences?

_____

_____

Part D — Nurse practitioner education

School name and address of each NP and master's program attended	Online/ distance? (yes or no)	Language of instruction	Date started (mm/yy)	Date completed (mm/yy)	Credential (e.g. diploma, master's)

Part E — Nurse practitioner registration status and experience

Complete all questions. If not applicable, write N/A.

1. Where did you first obtain registration as a nurse practitioner? _____

2. Date you first obtained registration (dd/mm/yy): _____

3. List all locations where you have been registered/licensed as a nurse practitioner:

_____

_____

4. List the jurisdiction(s) in which you hold your current nurse practitioner registration:

_____

5. What is your current professional title or designation in the jurisdiction in which you are currently registered (e.g. specialty NP, primary care NP): _____

6. List any current or past conditions, limitations or restrictions placed on your nurse practitioner registration by a regulatory body or employer or both (e.g. restricted to practise in oncology or pediatrics):

Condition/limit/restriction	Regulatory body/employer	Reason

7. Have you ever written a nurse practitioner licensing or credentialing examination? ☐ Yes ☐ No

If yes, complete the following:

Examination (e.g. ANCC)	Stream of practice (Family, Adult, Pediatric)	Date (dd/mm/yy)	Location

Part E — Nurse practitioner registration status and experience cont'd

8. Have you ever been certified by an agency that credentials nurse practitioners (e.g. ANCC, AANPCB, PNCB)?

☐ Yes ☐ No

If yes, identify the agency: _____

9. Have you been registered with any other profession? ☐ Yes ☐ No

If yes, what profession?: _____

10. Record the total number of hours for each year you worked as a nurse practitioner from January to December in the past three years. DO NOT include hours as a registered nurse (not applicable for new graduates):

Year	Hours worked as a nurse practitioner

Part F — Declaration, acknowledgment, undertaking and consent

I declare that:

- To the best of my knowledge, all the information that I submit in or with this application is true and complete.
- I do not have any existing physical or mental health conditions, including substance use disorder, that impairs my ability to practice safely and competently.
- Any health profession registration/licensure I have held in BC or elsewhere is not currently or previously been subject to any charge, investigation, inquiry or review by a regulator.
- I confirm that any health profession registration/licensure I have held in BC or elsewhere has not resulted in my registration being revoked, suspended or subjected to limits and/or conditions.
- I understand that falsification of a registration application, including the omission of requested information, or the submission of falsified documents to BCCNM, may be cause for BCCNM to deny registration, investigate, or take other appropriate action.
- I understand that it is an offence under the BC Health Professions Act for a person to apply for BCCNM registration or continue to be registered with BCCNM, if that person knows that he or she does not meet the conditions or requirements for BCCNM registration.

I acknowledge that:

- The information I submit in my application may be verified by BCCNM.
- Upon being granted registration, my name, date first registered, class of registration, and other information about me will be published on the BCCNM public register and is available to any person upon request as required by the Health Professions Act.
- BCCNM collects, uses and discloses information as authorized by the Health Professions Act and the BC Freedom of Information and Protection of Privacy Act.

Undertaking

- I undertake to practise my profession at all times in compliance with the Health Professions Act of British Columbia, applicable regulations, the BCCNM Bylaws and all applicable standards.

Consent for collection of additional information

- I consent to BCCNM asking any person, employer, government, educational institution, police force, military authority, governing body or other organization about anything relevant to my application for registration with BCCNM.

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

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Form 8.1A

Application for Nurse Practitioner Provisional Registration

Instructions

- Applicant completes Parts A and B
- Employer completes Part C if required
- Please complete all fields. If the form is incomplete, your registration will be delayed.

Part A — Personal information

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 B — Applicant acknowledgement and consent

By signing below, I acknowledge my full and complete understanding of the specific conditions indicated in Part D of this application form, and that I will honestly and truthfully inform any prospective employer(s) about each of these conditions. I also acknowledge that, once provisional registration has been issued, I will abide by these conditions at all times and if I am found to have breached any of them, I may be referred to BCCNM Professional Conduct Review and may be required to suspend practice.

By signing below, I give consent to any previous, current or future employers to release information regarding my competency in nursing to BCCNM to be used solely for the purpose of assessing my eligibility for registration in British Columbia.

By signing below, I acknowledge that, upon being granted registration, my name, registration number, status and all applicable conditions will be published on the BCCNM website in accordance with Section 22 of the Health Professions Act. 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 health care professionals.

By signing below, I acknowledge that I will submit a new application for nurse practitioner provisional registration if I change employers or wish to add a second employer.

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

Applicant name: _____

Part C — Employer monitoring agreement

Prior to offering employment to this applicant, please ensure that you understand the specific conditions noted in Part D of this form. These conditions will apply once provisional registration is issued. If you have questions, please email register@bccnm.ca. Please note: BCCNM cannot guarantee registration will be approved by the employment start date.

If the applicant's employment start date is unknown, do not complete this section or return this form to BCCNM.

Employer name: _____

Facility (specify name): _____Applicant employment start date (dd/mm/yy):_____

Facility representative name: _____Position/title: _____

Email:_____ Telephone (include area code): _____

According to BCCNM policies, "monitoring" means that the registrant holding provisional registration is monitored and evaluated by the appropriate individual (i.e., a physician or nurse practitioner). The monitoring individual should be on site or readily available so that the registrant can consult and/or collaborate as needed. Unless specified otherwise, monitored practice is in place for the duration of provisional registration. Please see www.bccnm.ca for more information.

By signing below, I confirm my full and complete understanding of the conditions specified in Part D of this form, and that they will apply to this applicant's provisional registration at the worksite indicated in Part C above once it has been issued. If any of the conditions specified in Part D are breached, I also understand that the provisional registrant may be subject to investigation by BCCNM Professional Conduct Review and may be suspended from practice.

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

Part D — Conditions on provisional registration

The following conditions will apply to provisional registration once issued:

- A condition that you are supervised by a registered nurse who holds nurse practitioner registration in B.C. or by a physician in good standing with the College of Physicians and Surgeons of British Columbia.
- A condition that you are not authorized to carry out independent prescribing or ordering of diagnostic tests.
- A condition that you write and pass the written and clinical nurse practitioner registration examinations.

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Form 17

Verification of Nurse Practitioner Registration

Instructions: Applicant must complete **Part A** and forward to each Regulatory Body from which original and all other nurse practitioner registrations were obtained. Photocopy this form if you have been registered in more than two provinces/states/countries. Send to each Regulatory Body with which you have been registered as a nurse practitioner so that they can complete **Part B. The Regulatory Body must forward this verification directly to BCCNM.**

PART A — Applicant

Last name: _____ First name: _____

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

Address (apt/box no.): _____ Number: _____ Street: _____

City/town: _____ Province/state/country: _____ Postal code/zip code: _____

Telephone (include area code): _____ Email: _____

Date of birth (month/day/year): _____

School where Nurse Practicioner program was completed: _____

Date graduated (month/year): _____

Nurse Practitioner registration date: _____ Nurse Practitioner registration no: _____

Date: _____ Signature:: _____

PART B — Regulatory Body for Nurse Practitioners

Name of regulatory body: _____

Name of registrant: _____ Registration no. _____

Type of Nurse Practitioner registration granted (title): _____

Registered by:

☐ Examination ☐ Endorsement

☐ National Certification. If yes, please identify certifying body and applicant's category of classification:

Certifying body: _____ Classification: _____

Initial registration date in jurisdiction: _____

Expiry date of registration: _____

Has this person's registration/licence ever been denied, revoked, suspended or under review? If yes, please indicate reason on reverse side. ☐ No ☐ Yes

If yes, has this person's registration/licence been reinstated? ☐ No ☐ Yes Date: _____

Name of Registrar or person completing this form: _____

Title: _____

Date (month/day/year): _____

(SEAL)

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Form 21

Application for Nurse Practitioner Examinations

Instructions

- Please complete both pages of this form in full and return it to BCCNM at register@bccnm.ca along with the payment form (form 33) and the correct fee. For more information, contact Registration Services.

Part A — Personal information

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 B— Practice stream

☐ Nurse practitioner (Family) ☐ Nurse practitioner (Adult) ☐ Nurse practitioner (Pediatric)

Part C — Written exam

Candidates will receive information about the written examinations after examination applications are received by BCCNM.

☐ **NP (Family) candidates:** Please refer to the following section of the BCCNM website for information on the NP (Family) written examinations recognized by BCCNM. You will need to make your own arrangements to complete one of the written examinations.

☐ **NP (Adult) candidates:** I am applying for the American Academy of Nurse Practitioners Certification Board (AANPCB) Adult-Gerontology Primary Care Nurse Practitioner Certification Exam. See fact sheet: www.ccrnr.ca/exams.html

☐ **NP (Pediatric) candidates:** I am applying for the Pediatric Nursing Certification Board (PNCB) Primary Care Pediatric Nurse Practitioner Certification Exam. See fact sheet: www.ccrnr.ca/exams.html.

Have you previously written the ANCC, AANPCB, PNCB or other? ☐ Yes ☐ No

If yes, please complete the following:

Exam name *(e.g. ANCC, AANPCB, PNCB)*	**Stream of Practice** *(Family, Adult, Pediatric)*	**Date** *(mm/dd/yy)*	**Location**

Part D — Objective Structured Clinical Examination (OSCE)

See Form 33 for fee information. Fees are subject to change without notice. An OSCE orientation package will be provided to you at a later date.

☐ I am applying for the Objective Structured Clinical Examination (OSCE)

☐ I am enclosing a certified passport photo. Note: A certified passport photo must accompany your OSCE application if you have not previously submitted a passport photo.

Part E — Exam date

Please visit our website to see upcoming exam dates and associated deadlines at https://www.bccnm.ca/NP/applications_registration/exams/Pages/Exam_dates.aspx and include your desired exam date and stream of practice below:

Desired exam date (dd/mm/yy): _____ Stream of practice: _____

The content, including examination questions of the written examination and the Objective Structured Clinical Examina-tion (OSCE) are highly confidential. Candidates partaking in the written exam and/or OSCE are prohibited from disclosing the content of the examination(s) and must not, under any circumstances, share or discuss any of the information they contain with any person except as authorized by the BCCNM. Unauthorized production, reproduction or publication of the examination material is prohibited. Unauthorized disclosure or receipt of the contents of the examinations or any other form of cheating is unethical behaviour and shall be dealt with in a serious manner by the regulatory authority and may lead to ineligibility for registration.

I acknowledge that I have read and understand the above provisions regarding examination confidentiality and cheating and agree to abide by them.

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

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www.bccnm.ca

Nurse Practitioner Professional Experience Record

Instructions

- Please complete both sides of this form. Consent for information on the reverse side of this form must be signed.
- Record the full name and mailing address of each nurse practitioner employment situation in the last three years. If addresses are incomplete, this form will be returned to you.
- Each employment situation must include the names of two referees who are either nurse practitioners or physician colleagues who work or worked directly with the applicant and is familiar with the applicant's practice. Wherever possible, the practitioner providing the reference should be in the same stream (family, adult or pediatric) as the applicant.

Part A — Personal information

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 B — Position 1

Position title: _____ Dates employed (dd/mm/yy): _____ to _____

Name of employing agency: _____

Stream of practice: ☐ Family ☐ Adult ☐ Pediatric

Employment status: ☐ Full-time ☐ Part-time ☐ Casual

Mailing address of employing agency: _____

_____

Referee 1

Name: _____

Title: _____

Address (if different than employer): _____

_____

Referee 2

Name: _____

Title: _____

Address (if different than employer): _____

_____

Part C — POSITION 2 (continued on page 2)

Position title: _____ Dates employed (dd/mm/yy): _____ to _____

Name of employing agency: _____

Stream of practice: ☐ Family ☐ Adult ☐ Pediatric

Employment status: ☐ Full-time ☐ Part-time ☐ Casual

Mailing address of employing agency: _____

Part C — Position 2 continued

Referee 1

Name: _____

Title: _____

Address (if different than employer): _____

_____

Referee 2

Name: _____

Title: _____

Address (if different than employer): _____

_____

Part D — Position 3

Position title: _____ Dates employed (dd/mm/yy): _____ to _____

Name of employing agency: _____

Mailing address of employing agency: _____

_____

Stream of practice: ☐ Family ☐ Adult ☐ Pediatric

Employment status: ☐ Full-time ☐ Part-time ☐ Casual

Referee 1

Name: _____

Title: _____

Address (if different than employer): _____

_____

Referee 2

Name: _____

Title: _____

Address (if different than employer): _____

_____

Part E — Other nurse practitioner experience since graduation from NP education program

Dates (mm/dd/yy)	Position	Unit/Area	Status	Name/location of employing agency
From: To:			☐ Full-time ☐ Part-time ☐ Casual	
From: To:			☐ Full-time ☐ Part-time ☐ Casual	
From: To:			☐ Full-time ☐ Part-time ☐ Casual	
From: To:			☐ Full-time ☐ Part-time ☐ Casual	

CONSENT FOR INFORMATION TO BE RELEASED TO BCCNM

I, _____,hereby give consent for any of my current or previous employers to release reference(s) regarding my competence as a nurse practitioner to the British Columbia College of Nurses and Midwives to be used solely for the purpose of assessing my application for registration as a nurse practitioner in British Columbia.

Signature: _____ Date: _____

British Columbia College of Nurses & Midwives

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www.bccnm.ca

Form 24

Nurse Practitioner: Request for Transcript

Authorization to share nurse practitioner educational program transcripts with BCCNM

Instructions

- Most schools require a fee to prepare a transcript. To avoid delay, contact your school and inquire about the fee.
- Complete this form and send it, along with the fee, to each nurse practitioner program where courses were completed.
- The school must send transcripts directly to BCCNM Registration Services.

Part A — Personal information: To be completed by applicant

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: _____

Date of graduation (mm/dd/yy): _____ Degree received: _____

Part B — Authorization to release transcripts

I hereby authorize the release of my transcripts to the British Columbia College of Nurses and Midwives for the purpose of obtaining registration as a nurse practitioner in British Columbia.

Please send my complete final transcripts to BCCNM. Please mail transcript(s) directly to:

Registration Services
British Columbia College of Nurses and Midwives
900-200 Granville Street
Vancouver, BC V6C

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

British Columbia College of Nurses & Midwives

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Email: register@bccnm.ca
www.bccnm.ca

NP Application/Assessment/Examination Payment Form

Instructions

- All fees must be paid in Canadian funds
- Fees are subject to change and are non-refundable.

Part A — Personal information

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 B — Fees

Examination fees	**Fee**	**Amount**
☐ OSCE fee	$2,530.00	_____
Application fees (including GST) - Check ONE		
☐ Application Assessment Fee (for graduates of a B.C. NP program)	$265.00	_____
☐ Application Assessment Fee (for graduates of a Canadian NP program)	$345.00	_____
☐ Application Assessment Fee (for graduates of an international NP program)	$690.00	_____
	Total:	_____

Part C — Payment

You will be sent an email with a link to the payment page once your application has been received.

BCCNM accepts the following payment methods:

- Credit card (VISA, American Express and MasterCard)
- Visa Debit
- INTERAC Online

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Email: register@bccnm.ca
www.bccnm.ca

Nursing Employment Verification

Instructions

- BCCNM will use the information provided in this form to assess the applicant's application for registration with the BCCNM. **The reference form must be submitted to BCCNM directly by the employer.**
- To avoid delays in the application process, make sure Sections A to C are complete, then provide to your current or previous nursing employer to complete Sections D to G. Provide an Employment Verification for each nursing employer in the last five years.
- The applicant must submit a resume of their nursing employment to BCCNM.
- The applicant must list all facility names within that health authority that this form is for.

PART A — Personal information (to be completed by applicant)

Last name: _____ First name: _____ BCCNM ID: _____

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

Part B — Employment information (to be completed by applicant)

Area of nursing you work/worked in: ☐ Clinical practice ☐ Administration ☐ Education ☐ Research

Facility name: _____

Health authority (if applicable): _____

Employer address (Apt/Box/#/Street): _____ City/town: _____

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

Manager name: _____

Title: _____

Telephone: _____ Email: _____

Area of nursing you work/worked in: ☐ Clinical practice ☐ Administration ☐ Education ☐ Research

Facility name: _____

Health authority (if applicable): _____

Employer address (Apt/Box/#/Street): _____ City/town: _____

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

Manager name: _____

Title: _____

Telephone: _____ Email: _____

Part B — Employment information (to be completed by applicant) (cont'd)

Area of nursing you work/worked in: ☐ Clinical practice ☐ Administration ☐ Education ☐ Research

Facility name: _____

Health authority (if applicable): _____

Employer address (Apt/Box/#/Street): _____ City/town: _____

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

Manager name: _____

Title: _____

Telephone: _____ Email: _____

Part C — Consent & Declaration (to be completed by applicant)

I give consent to any and all current and previous employers to release information regarding my conduct, fitness, and competence in nursing to BCCNM to be used solely for the purpose of assessing eligibility for registration in British Columbia.

I declare that the information I have provided on this form is true and accurate. I understand that falsification of this document, or the submission of any falsified documents to BCCNM, may be cause for BCCNM to withhold registration, revoke registration or take other appropriate action.

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

Part D — Employment information (to be completed by employer)

The individual above has applied for registration with the BC College of Nurses and Midwives (BCCNM). In order to determine if the applicant meets the requirements for registration, we would appreciate your assistance by completing the questions below. This form should be completed by HR or the supervisor/manager most familiar with the applicant's nursing practice during the time of employment. To avoid delays, all sections of this form must be completed.

Both pages of this form must be sent directly to BCCNM by the employer by email at register@bccnm.ca.

Date employed from (dd/mm/yy): _____ to: _____

If currently on LTD, maternity or other type of leave, what date did the leave begin? (mm/dd/yy): _____

Job title: _____ ☐ Full-time ☐ Part-time ☐ Casual

Department(s) employed in: _____

Language spoken in the workplace: _____

Language used for documentation: _____

Is nursing registration required to hold this position? If yes, please indicate what type of nursing registration:

☐ LPN ☐ RN ☐ RPN ☐ Other

Important: Please attach a job description for the position described.

Part E — Nursing practice hours in the past five years (to be completed by employer)

Provide the nursing practice hours for each calendar year (January 1 - December 31) of employment for the past **five** years. Hours must only include actual practice hours worked (excluding seniority, vacation, LTD/sick leave, paid/unpaid leave, etc.

Last year worked: _____ Hours: _____

Previous year: _____ Hours _____

Previous year: _____ Hours _____

Previous year: _____ Hours _____

Previous year: _____ Hours _____

EXAMPLE:

Last year worked:	2020	Hours: 1,600
Previous year:	2019	Hours: 2,150
Previous year:	2018	Hours: 0
Previous year:	2017	Hours: 1,850

Part F — Conduct (to be completed by employer)

Has the applicant ever been investigated, disciplined, terminated or allowed to resign in lieu of termination?

☐ Yes ☐ No

Is this individual eligible for rehire? ☐ Yes ☐ No

Part G — Employer information (to be completed by employer)

Last name: _____ First name: _____

Title: _____

Telephone: _____ Email: _____

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

IMPORTANT: Please email the completed reference (both pages) directly to register@bccnm.ca.

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Email: register@bccnm.ca
www.bccnm.ca

Nurse Practitioner Program Information Request

Part A. To be completed by Applicant and sent to Nurse Practitioner Education Program Director

Instructions: Complete Part A and forward a copy of this form to each educational institution from which you received credit for completed nurse practitioner courses. An official transcript is required and must be forwarded directly from the institution to BCCNM.

I am applying for registration as a nurse practitioner in British Columbia. A detailed record of my nurse practitioner education program is required.

Last name: _____ First name: _____

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

Date of birth (mm/dd/yy): _____ Date graduated: _____

School where nurse practitioner program completed: _____

Address of school: _____

Date: _____ Signature: _____

Part B: To be completed by Nurse Practitioner Education Program Director and sent to BCCNM

Instructions: Complete Part B and forward this form and all requested documents to BCCNM Registration Services at register@bccnm.ca or 900–200 Granville St Vancouver, BC V6C 1S4 Canada.

1. Request for Documents

Please enclose a copy of the four documents listed below. All documents must be for the period of time when the applicant was enrolled in the education program.

- ☐ a description of the nurse practitioner program, including admission criteria, mission, philosophy, goals and objectives, and all requirements for successful completion of the program; and
- ☐ one copy of all course descriptions and accompanying course outlines in the program as they were taught during the academic term in which each was completed by the applicant; and
- ☐ one copy of the policies and procedures for the supervision and evaluation of student clinical practice, including assignment of preceptors (if applicable) the qualifications of faculty and preceptors, and the role of the nursing faculty in supervising clinical practicum placements and student evaluation; and
- ☐ one copy of the policies and procedures handbook for students about their clinical practicum assignment and evaluation.

2. Nurse Practitioner Program Information

Type of school (e.g., college, university, vocational): _____

Type of nurse practitioner program (e.g., family, pediatric, adult): _____

Program approval/accreditation body: _____

Date approved/accredited:_____For how long was approval/accreditation granted?_____

Is this an Online Program? ☐ Yes ☐ No

Date applicant commenced:_____ Date applicant graduated: _____

Credential awarded (specify degree, certificate or diploma): _____

Total length of program in months (include clinical practicum*): _____

Program hours: total theoretical: _____ Total clinical practicum*: _____

*The clinical practicum hours indicated must include direct client care wherein the nurse practitioner student learning opportunity is focused on assessing individual clients and diagnosing and managing diseases, disorders and conditions. The practicum includes ordering diagnostic tests (laboratory and imaging), prescribing medications and requesting physician consultation. DO NOT include hours spent in skill labs, physical assessment practice sessions or community projects.

3. Theoretical and Clinical Practicum Preparation

i. Populations

Indicate what populations were included in the applicant's theoretical and clinical preparation. Indicate the combined hours spent with each population.

Perinatal: ☐ Yes _____ hours ☐ No Pediatrics: ☐ Yes _____ hours ☐ No

Adult: ☐ Yes _____ hours ☐ No Older adult: ☐ Yes _____ hours ☐ No

ii. Areas of Competence

Identify the correlating course(s), as outlined in the course descriptions, where the following areas of competence were taught in the applicant's program.

Professional Role, Responsibility, and Accountability	Course Number
The nursing role of the nurse practitioner and professional accountability	
Health care systems, regulatory frameworks, and legal and ethical practice	
Research methods and evaluation of research for evidence based practice	
Leadership, collaboration and change	
Quality improvement and risk management at the individual and system level	
Documentation	
Assessment and Diagnosis	
Pathophysiological basis of disease equivalent to a full three credit semester course	
Comprehensive and holistic physical and psychosocial assessment of all client groups appropriate to the stream of practice equivalent to three credit semester course	
Critical thinking, clinical and diagnostic reasoning and differential diagnosis	
Ordering and interpretation of diagnostic and/or screening investigations	
Diagnosis of common acute and chronic physical and mental diseases, disorders and conditions	
Communication of findings	
Documentation of findings	
Health Care Management	
Principles of pharmacotherapeutics, including pharmacokinetics and pharmacodynamics, equivalent to a three credit semester course	

Professional Role, Responsibility, and Accountability	Course Number
Treatment (including appropriate prescribing and dispensing) of client's acute and chronic physical and mental diseases, disorders and conditions	
Documentation of plan of care	
Consultation and referrals	
Follow-up and information systems	
Health Promotion and Illness/Injury Prevention	
Identify and respond to trends or patterns that have health implications for clients	
Contribute to health promotion/prevention strategies	
Advocate for clients and their health care needs by encouraging participation of clients, by advocating for policies and by providing leadership	

iii. Clinical Practicum

Indicate yes or no for each criterion below.

Clinical Practicum	Yes	No	Comments
Final decision regarding practicum placement is made by faculty			
Students are precepted by NPs or MDs in close collaboration with faculty			
Student progress is evaluated by nursing faculty in consultation with preceptor, and includes on-site visits by faculty			
Applicable to Nurse Practitioners (Family): Context of clinical practicum is general primary care settings and is usually in, but not limited to, community clinics, health care centres or other community settings			
Applicable to Nurse Practitioners (Adult) and (Pediatrics): Context of clinical practicum is acute, residential care and community settings			

Name of Person Completing Form:

_____

Title:

_____

Signature:

_____

Telephone:

_____

E-mail:

_____

School Seal

If your institution does not have school seal, include a cover letter on school letterhead, with original signature, attesting to the veracity of the information provided on this form. If you have any questions pertaining to the form, contact BCCNM Registration Services at register@bccnm.ca.