

Complete Section 1 and forward it to your nursing or health care employer. Section 1 is to be completed by the applicant; Section 2 is to be completed by the employer. Once completed, the original form (no photocopies) form must be issued directly from the employer to the CLHA. Copies will not be accepted. Forms may be submitted by email to lpnregistration@clha.com, or by mail to the address listed at the end of section 2.

SECTION 1 (to be completed by the applicant):

First Name	Last Name	Registration Number
Phone Number		Email
Address		
City	Province	Postal Code

Consent to Release Information

I am seeking registration as a Licensed Practical Nurse in Alberta. In order to process my application, the College of Licensed Practical Nurses and Health Care Aides of Alberta (CLHA) is requesting information regarding my employment with your facility. I hereby give my consent to you to provide any and all information to the CLHA regarding my competency in nursing practice. This shall constitute your legal authority to provide this information and any other information the CLHA may request relevant to my application. I was employed with your facility between the dates of:

Date Employment Commenced and Concluded:

Signature:

Date Signed:

Privacy Statement

I acknowledge that the information collected in this form will be used for the purposes of assessing my application for registration. This information will be maintained on my file and may also be used to assess my application for renewal of my practice permit in the future or for the purposes a discipline proceeding under Part 4 of the *Health Professions Act*. Information collected in this form including geographical, education, and employment information may also be disclosed to non-profit organizations and institutions for the purposes of health policy making and health human resource planning. No other disclosure of this information will be made except in accordance with the provisions of the *Health Professions Act*, the Licensed Practical Nurses and Health Care Aides Profession Regulation, the *Personal Information Protection Act*, or as otherwise permitted by law. Please see the CLHA's [Privacy Policy](#) for additional information.

Signature:

Date Signed:

SECTION 2 (to be completed by the employer):

Employment Contact Information

First Name	Last Name	Email	
Fax Number	Phone Number		
Address			
City	Province	Postal Code	Country

Employment Details

Start Date	End Date	Title/Position held by Employee
Name of Employee	Supervisor Name and Job Title	
Has the employee ever been disciplined? Yes No		Has the employee ever been terminated? Yes No

If the employee has been disciplined and/or terminated, please indicate why this action was taken below or attach a document explaining the details.

SECTION 2 (continued):

Employment Hours

Please print and check the applicable box

Year Employed	Total Hours Worked	Employment Status
2022		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
2023		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
2024		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
2025		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
2026		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

Employer Confirmation

Name (please print):

Professional designation:

Registration/License #:

E-mail:

Telephone:

Signature:

Date:

Please ensure that this completed form, along with any other relevant information, is sent directly to:

Deputy Registrar
College of Licensed Practical Nurses and Health Care Aides of Alberta
St. Albert Trail Place
13163 146 Street,
Edmonton, Alberta T5L 4S8