

BACHELOR OF NURSING (COLLABORATIVE) PROGRAM

STUDENT INFORMATION FORM

Name: _____ Date of Birth: ____/____/____
(First) (Middle) (Last) (Day) (Month) (Year)

Student Number: _____ Health Card Number (i.e., MCP, OHIP): _____

MUN Email Address: _____

Permanent Address: _____ Telephone: _____

_____ Postal Code: _____

Local Address: _____ Telephone: _____

_____ Postal Code: _____

Person to be notified in case of emergency:

Name and Relationship: _____

Address: _____ Telephone: _____

1. All nursing students must read the College of Registered Nurses of Newfoundland and Labrador (CRNNL) document “Requisite Skills and Abilities for Entry-Level Registered Nurse Practice” to determine their ability to meet the requirements of the program. It is the student’s responsibility to disclose any information that may require accommodation during the completion of their program.

https://www.arnnl.ca/sites/default/files/RD_Guidelines_For_Requisite_Skills_And_Abilities.pdf

This signature confirms you have read the above document:

Student Signature: _____ Date: _____

2. As applicable, students are accountable to inform faculty if they have:
 - Allergies to any drug and/or material such as penicillin and/or latex
 - Medical condition(s) that may require immediate treatment.

This signature confirms you have read the above statement:

Student Signature: _____ Date: _____

All information requested by the Bachelor of Nursing (Collaborative) Program will be used solely for the administration, management, and delivery of the program. Personal information is collected under the authority of the Memorial University Act (RSNL 1990 Chapter M-7), under the authority of Sections 61 and 62 of the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act. Questions about this collection, use, and disclosure of personal information and personal health information may be directed to the Clinical Program Administrator at 709-864-8352.