MISSISSIPPI LPN ASSOCIATION

P.O. BOX 1495

LAUREL, MS

PRE- ADMISSION SCREENING FORM FOR LPN EXPANED ROLE IN IV THERAPY

Name as it appears on your MS LPN License:

Last First Middle Maiden

Home Address:

Street City State Zip

Phone (Cell) _____ (H) _____ (W)_____

Email: _____LPN License Number: _____

Did you graduate from a state approved practical nurse educational program or an equivalent state approved program? Yes or No (circle one)

Name of Program: _____

Location: _____

Year of Graduation: _____

Have you had one year of clinical experience as a LPN within the past 3 years? Yes or No (Circle one)

List your employment history with dates for the past 3 years. Start with your current employer.

1. _____ Dates_____ Phone _____

2. _____ Dates_____ Phone _____

3. _____ Dates_____ Phone _____

This is to certify that the above named LPN has met all admission requirements for the IV Therapy Course. Date: _____ RN Instructor Signature_____

Copied from form #PIV16 5/05 MBON