

**THE NURSING COUNCIL OF ST. VINCENT & THE GRENADINES  
P.O. BOX 1175, LARGO HEIGHT  
KINGSTOWN  
ST.VINCENT  
APPLICATION FOR LICENSURE FORM**

**Form 1:** (To be completed in Applicant's handwriting using **BLOCK LETTERS** and taken or sent to the General Nursing Council supported by original documents):

A. NAME .....  
   **SURNAME**  **first**  **middle**

Date of Birth .....AGE:.....

Postal Address: .....

Email:..... Contact #:.....

Marital Status ..... Nationality.....

Application to be registered as: RN  Midwives  Nursing Assistant

B. **Basic Education** (Give name of educational institutions & dates of attendance).

Secondary..... From ..... To .....

College ..... From ..... To .....

University ..... From ..... To .....

**QUALIFICATIONS RECEIVED**

Secondary .....

College .....

University .....

C. **Particulars of TRAINING:**

Name and Address of INSTITUTION OF TRAINING:-.....  
 .....

Dates of Training: From ..... To .....

Type of Certificate/Diploma/ Degree gained: .....

D. **Particulars for Registration**

Date of Registration in Country of Training: .....

Initial Registration Number: .....

NAME AND ADDRESS of REGISTERING BODY: .....

Date of Current Registration ..... Reg. #..... Country.....

E. Post-registration qualifications gained (e.g. Certificates/ Diplomas/Degree etc).

.....Date .....

.....Date .....

.....Date .....

F. Employment **FOLLOWING** Nurse Registration:

.....FROM.....TO .....

.....FROM.....TO .....

.....FROM.....TO .....

Signature of Applicant:..... Date.....



**(Complete from records of the Training Institution)**

Professional Adjustment:-

.....  
.....  
.....

Attitude & Behaviour:-

.....  
.....  
.....

Clinical Performance:-

.....  
.....  
.....

5. Date of Graduation:.....

6. CERTIFICATE OF AUTHORITY:-

I, .....  
*(Give Official Title)*

of .....  
*(Training Institution)*

**DO CONFIRM** that the Particulars entered on the reverse side of this document by the Applicant with respect to Training and Registration are **TRUE** and **CORRECT**.

**NAME OF AUTHORITY (Please Print)**.....

Signature of Authority..... Stamp of Authority

Mailing Address of AUTHORITY.....

.....

Date of Processing: - .....

**FORM 3** The applicant should fill section A of this form and take or send to the Registering Body in their country. The Form is to be returned **DIRECTLY** to the Office of the Nursing Council of St. Vincent and the Grenadines by the Authority, National Aids Secretariat Building, Largo Height, P.O. Box 1175. Forms returned by Applicants will not be processed.

A. NAME .....  
**SURNAME**                          **first**                          **middle**  
Date of Birth ..... AGE:.....  
Postal Address: .....  
Email:..... Contact #:.....  
Marital Status ..... Nationality.....  
Application to be registered as: RN  Midwives  Nursing Assistant

**Section B (to be FILLED BY Initial Registering Body and submitted directly to the General Nursing Council)**

Is this your initial registration? Yes  No   
If no complete Section B

B. **Particulars for Registration**

Date of Registration in Country of Training: .....  
Initial Registration Number: .....  
NAME AND ADDRESS of REGISTERING BODY:  
.....  
Date of Current Registration ..... Reg. #..... Country.....  
Post-registration qualifications gained (e.g. Certificates/ Diplomas/Degree etc).  
.....Date .....  
.....Date .....  
.....Date .....  
Name of Authority:.....  
(BLOCK LETTERS)  
Signature of Authority..... Stamp of Authority  
Date:.....

I certify that the above information is correct and authentic.....

**Section C to be filled by the General Nursing Council – St. Vincent and the Grenadines**

C. Date Received.....  
Approval Granted:..... Denied:.....  
If Denied give reason.....  
.....  
Fees of \$..... Receipt #.....  
Registration #:..... Initial Date:.....  
Name of Authority:.....  
(BLOCK LETTERS)  
Signature of Authority..... Date:.....