THE NURSING COUNCIL OF ST. VINCENT & THE GRENADINES P.O. BOX 1175, LARGO HEIGHT KINGSTOWN ST.VINCENT

APPLICATION FOR LICENSURE FORM

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

A.	NAMESURNAME	first	middle					
	Date of Birth	AGE:						
	Postal Address:							
	Email:	Contact #:						
	Marital Status Nationality							
	Application to be registered as: RN	Midwives	Nursing Assistant					
B.	ance).							
	Secondary	From	То					
	College	From	То					
	University	From	То					
	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 Tr	raining:						
	Initial Registration Number:							
	NAME AND ADDRESS of REGISTER	ING BODY:						
	Date of Current Registration	Reg. # Co	ountry					
E.	Post-registration qualifications gained (e.g. Certificates/ Diplomas/Degree etc).							
L.								
		D:	ate					
F.	Employment FOLLOWING Nurse Regi							
		FROM	TO					
		FROM	TO					
		FROM	TO					
	Signature of Applicant:	Date						

FORM. 2

TRAINING INSTITUTION who will ensure that an **ORIGINAL TRANSCRIPT OF**TRAINING AND EXPERICENCE of the Applicant is attached. The Form and Transcript are then 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.

Α. To be completed in handwriting by Applicant using **BLOCK LETTERS** and taken or sent to the Training Institution): SURNAME Date of BirthAGE:.... Postal Address: Nationality Midwifery \square Nursing Assistant \square RENR □ Examination Type: I hereby give consent for the information requested on these forms to be divulged to the relevant persons. Signature:.... В To be completed by Training Institution 1. Name of TRAINING INSTITUTION OF APPLICANT: -Address: -2. TOTAL BED CAPACITY of Health Institution to which Applicant was attached = beds, comprising of: Medical Surgical = = Paediatric Obstetric = Gynecological = Any Other (state) =..... If experiences of Applicant were received in affiliated institutions, please state:-3. Length of BASIC NURSING PROGRAMME offered by Training Institution:-TOTAL experiences stipulated by Programme of Training:-CLINICAL = THEORY = Applicant COMMENCED Programme of Training on Applicant COMPLETED Programme of Training on 4. Experiences **ACTUALLY RECEIVED** by Applicant over period of Training:-

CLINICAL = THEORETICAL =

(C	omplete from records of the Training Institution)				
	Professional Adjustment:-				
	Attitude & Behaviour:-				
	Clinical Performance:-				
	Chinical Ferrormance				
5.	Date of Graduation:				
<i>5</i> . 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				
	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

	SURNA	ME	first	middl e	
	Date of Birth		AGE:		
	Postal Address:				
	Email:	• • • • • • • • • • • • • • • • • • • •	Contact #:		
	Marital Status	Nation	ality		
	Application to be registered	as: RN	Midwives	☐ Nursing Assistant	
Section	B (to be FILLED BY Initial	l Registering B	ody and submit	ted directly to the General Nu	rsin
	Is this your initial registration	on? Yes 🗌	No 🗌		
	If no complete Section B				
В.	Particulars for Registration				
	Date of Registration in	Country of Train	ining:		
	Initial Registration Nun	nber:			
	NAME AND ADDRES	S of REGISTE	RING BODY:		
				Country	
	Post-registration qualificat	ions gained (e.g	g. Certificates/ Di	plomas/Degree etc).	
				Date	
				Date	
				Date	
	Name of Authority:				
		(B)	LOCK LETTERS)		
	Signature of Authority			Stamp of Authority	
	Date:				
	I certify that the above infor	mation is correct	ct and authentic.		
	Section C to be filled by the	e General Nursi	ing Council – St.	Vincent and the Grenadines	
C.	Date Received				
	Approval Granted:		De	nied:	
	If Denied give reason				
	Fees of \$	Receipt #			
	Registration #:		Initial Date	:	.
	Name of Authority:				
	Cianatan CA (1)	•	LOCK LETTERS)	Deter	
	Signature of Authority			Date:	