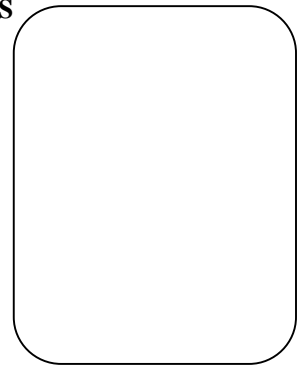


**THE GENERAL NURSING COUNCIL of ST. VINCENT & THE GRENADINES  
P.O. BOX 1175  
LARGO HEIGHT  
KINGSTOWN  
ST.VINCENT – WEST INDIES**



**APPLICATION TO WRITE QUALIFYING EXAMINATION FORM**

**SECTION I:** (To be completed in handwriting by Applicant using **BLOCK LETTERS** and taken or sent to the Educational Institution):

A. NAME .....  
SURNAME
first
middle

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

Address: .....

Postal.....

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

Marital Status ..... Date of Marriage (if applicable).....

Nationality .....

Examination Type:    RENR          Midwifery          Nursing Assistant   

Candidate Status:    First Sitter          Re-sitter   

B. **Basic Education** (Give name of educational institutions, dates of attendance Basic education Certificates/ Diplomas).

Secondary .....Date ..... Qualification .....

College ..... Date ..... Qualification .....

University.....Date .....Qualification.....

Other... .....Date ..... Qualification. ....

C. **Professional Training:**

Name of Programme completed:-.....

Name and Address of Institution:  
 .....  
 .....  
 .....

Level of Programme completed: - .....

.....  
 Signature of Applicant Date:

**SECTION II** (To be completed by Training Institution)

Date of Programme – From : ..... To: .....

Qualifications Obtained: .....

If Programme was not completed, please state reason (s):

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

Date qualifications were obtained: .....

Graduation Date: .....

Length of Training Programme: .....

Language of Training Programme: .....

TOTAL experiences stipulated by Programme of Training:-

CLINICAL = ..... THEORETICAL = .....

Experiences **ACTUALLY RECEIVED** by Applicant over period of Training:-

CLINICAL = ..... THEORETICAL = .....

**Complete from records of the Training Institution:**

Professional Adjustment:

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

Attitude & Behaviour:

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

Clinical Performance:.....

.....  
.....

Attendance and Punctuality:.....

.....

Recommendation to write Qualifying Examination:

YES

NO

If NO, please state why:

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

**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: - .....

**SECTION III** (To be completed by Examining Body)  
General Nursing Council

Date Received.....

Approval Granted:.....

Denied:.....

If Denied give reason.....

.....

.....

.....

Name of Authority:.....

**(BLOCK LETTERS)**

Signature of Authority.....

Stamp of Authority

Date:.....