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……..

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……

……

Name of Authority:……
(**BLOCK LETTERS**)

Signature of Authority…… Stamp of Authority

Date:……