



900—200 Granville St.  
 Vancouver, BC  
 Canada V6C 1S4  
 www.bccnm.ca

Tel: 604.742.6200  
 Toll-free: 1.866.880.7101  
 Fax: 604.899.0794  
 Email: register@bccnm.ca

## Verification of Nurse Registration

**APPLICANT:** Complete Part A of this form and forward a copy to each regulatory body in which you have been registered/licensed.

### Part A: PLEASE PRINT

Name \_\_\_\_\_  
Last Name First Name Middle Name

Former Name if any \_\_\_\_\_

Address \_\_\_\_\_  
Apt./Box No. Number Street

\_\_\_\_\_ City/Town Province/State Country Postal/Zip Code

Telephone (include country code) \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth (day/month/year) \_\_\_\_\_

Nursing school where you completed your basic program \_\_\_\_\_

Date Graduated (month/year) \_\_\_\_\_

Initial Nurse Registration Date (day/month/year) \_\_\_\_\_

Nurse Registration Number \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

*I am applying for nurse registration in British Columbia. A record of my nurse registration is required.*

**REGULATORY BODY:** Complete Part B of this form and mail it to BCCNM Registration Services.

### Part B: PLEASE PRINT

Name of Regulatory Body \_\_\_\_\_

Name of Registrant \_\_\_\_\_ Registration Number \_\_\_\_\_

Type of Registration Granted (title) \_\_\_\_\_

Initial Registration Date \_\_\_\_\_ Expiry Date of Registration \_\_\_\_\_

Registered by  Examination  Endorsement

Has this person's registration/licence ever been denied, revoked, suspended or under review?  No  Yes

Examination Written  CAN Testing Service  NLN State Board Test Pool  NCLEX  Other (specify) \_\_\_\_\_

Number of Writings \_\_\_\_\_ Date of Exam \_\_\_\_\_ Passing Score \_\_\_\_\_

Name of Registrar or Person Completing this Form \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_