Other Surnames: your surname at birth, your maiden name

or other former names



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

Middle Name

CONFIRMATION OF REGISTRATION (Canadian RPN regulatory bodies)

This form is for applicants for registration as an RPN registration, and RPN registrants.

INSTRUCTIONS TO THE APPLICANT:

Surname/Family Name

Please complete Section A only and forward the form to your current or former regulatory body.

First or Given Name

| SECTION A | : |
|-----------|---|
|-----------|---|

Name:

A J J....

| Oate of Birth: | Registration number: | | | |
|--|---|--|--|--|
| give my consent to you to provide the information requicollege of Nurses and Midwives. Date: | ested in either Section | n B or C, as applicable, directly to the BC | | |
| DD-MM-YYYY | Applicant's signature | | | |
| STRUCTIONS TO THE REGISTERING BODY: ease provide the following information concerning the registres and return this form directly to the BC College of Nurse plicant) | es and Midwives. (Note | e: This is not to be sent by the | | |
| CTION B – REGISTRANTS: The records of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the following state in the control of the regulatory body indicate the control of t | | | | |
| | | - | | |
| | orogram in psychiatric i irrent registration expii | - | | |
| on DD-MM-YYYY | | res or expired: | | |
| On Date cu DD-MM-YYYY Status of Applicant's registration: | nrent registration expi | res or expired: DD-MM-YYYY | | |
| The above named has successfully completed an approved posterior on Date cure of Deficient on Deficient on: Status of Applicant's registration: Method by which the Applicant was registered: Is Applicant eligible for registration in your jurisdiction? | urrent registration expin | res or expired: DD-MM-YYYY Non-Practicing | | |
| on Date cu DD-MM-YYYY Status of Applicant's registration: Method by which the Applicant was registered: | Practicing Examination | res or expired: DD-MM-YYYY Non-Practicing Endorsement | | |
| on Date cure DD-MM-YYYY Status of Applicant's registration: Method by which the Applicant was registered: Is Applicant eligible for registration in your jurisdiction? | Practicing Examination Yes Year: Year: Year: Year: Year: | res or expired: DD-MM-YYYY Non-Practicing Endorsement No Hours: Hours: Hours: Hours: | | |

SECTION B cont'd: The records of the regulatory body indicate the following:

| | , | | 8- | | | | |
|---|-------|-------|-----------------------|-------------------|-------|--|--|
| If you answer "Yes" to any of the following questions, please provide details on a separate sheet of paper. | | | | | | | |
| Does the registration/license of this psychiatric nurse have any current conditions or limitations? | | | | | □No | | |
| Is this psychiatric nurse currently under investigation? | | | | | □No | | |
| Has the registration/license of this psychiatric nurse ever been encumbered, suspended, revoked, or denied? | | | | | □No | | |
| Does the psychiatric nurse have any physical/mental condition, disorder, and/or addiction impairing his/her ability to practice as a nurse? | | | | | □No | | |
| SECTION C - ELIGIBLE TO REGISTER: The records of the regulatory body indicate the following: | | | | | | | |
| the records of the regulatory body indicate the following: | | | | | | | |
| The above named has successfully completed an approved program in psychiatric nursing at: | | | | | | | |
| NAME OF SCHOOL | | | On DD-M | M-YYYY | | | |
| Is the applicant eligible for registration in your jurisdiction | YES 🗌 | по □ | | | | | |
| Has the applicant registered for the RPNCE? | YES 🗌 | NO 🗌 | LOCATION | DD MM | NANA. | | |
| Has the Applicant passed a registration/licensing exam? | YES 🗌 | NO 🗌 | LOCATION Year of Exa | DD-MM- <u></u> | -YYYY | | |
| Was the exam given in English? | Yes 🗌 | NO 🗌 | | | | | |
| Practice hours, if applicable, for the past five years: | | Year: | Hours | S: | | | |
| | | Year | Hours | S: | | | |
| | | Year: | Hours | 3: | | | |
| | | Year: | Hours | S: | | | |

| Name (please print your complete name) | Title (please indicate your official title) |
|---|---|
| Phone number (include country code if outside Canada) | Email Address |
| Date: | |
| DD-MM-YYYY | Signature |

Year:

Hours:

IMPORTANT: Please send the completed form directly to BCCNM Registration Services by email at register@bccnm.ca, or by mail to 900-200 Granville Street, Vancouver BC, Canada V6C 1S4.