Form 25

British Columbia College of Nurses & Midwives

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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_____