

## REGISTRATION/LICENSURE VERIFICATION

☐ LPN | ☐ RN | ☐ NP | ☐ RPN (CHECK ALL THAT APPLY)

NSNMR APPLICATION NUMBER (IF KNOWN): \_\_\_\_\_

300 - 120 Western Parkway  
Bedford, Nova Scotia B4B 0V2  
Tel: 902-444-6726  
Toll-free (NS) 1-833-267-6726  
fax: 902-377-5188  
registration@nsnmr.ca

## SECTION A - APPLICANT

Complete Section A then forward to the registering/licensing authority requesting they verify your status by completing Section B.

|                                |                 |                            |
|--------------------------------|-----------------|----------------------------|
|                                |                 |                            |
| SURNAME                        | GIVEN NAMES     | BIRTH/FORMER NAME          |
|                                |                 |                            |
| SCHOOL OF NURSING AND LOCATION |                 | DATE OF BIRTH (YYYY-MM-DD) |
|                                |                 |                            |
| YEAR OF GRADUATION             | YEAR REGISTERED | REGISTRATION NUMBER        |
|                                |                 |                            |
| SIGNATURE                      |                 | DATE (YYYY-MM-DD)          |

## SECTION B – REGISTERING/LICENSING AUTHORITY

Please return completed form by mail directly to the Nova Scotia Nursing and Midwifery Regulator at the address above.

|                                                                                                                                                                                              |                                      |                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------|
| ACTING ON BEHALF OF THE                                                                                                                                                                      |                                      |                                      |
|                                                                                                                                                                                              |                                      |                                      |
| REGISTERING AUTHORITY                                                                                                                                                                        |                                      |                                      |
| I DO HEREBY CERTIFY THAT                                                                                                                                                                     |                                      |                                      |
|                                                                                                                                                                                              |                                      |                                      |
| SURNAME                                                                                                                                                                                      | GIVEN NAMES                          |                                      |
|                                                                                                                                                                                              |                                      |                                      |
| BIRTH/FORMER NAMES                                                                                                                                                                           | DATE OF BIRTH (YYYY-MM-DD)           |                                      |
| <input type="checkbox"/> BY CHECKING THIS BOX, I CONFIRM THAT THE APPLICANT NAMED IN SECTION A AND THE INDIVIDUAL WE, THE REGULATORY BODY, HAVE IDENTIFIED IN SECTION B ARE THE SAME PERSON. |                                      |                                      |
| A GRADUATE OF                                                                                                                                                                                |                                      |                                      |
|                                                                                                                                                                                              |                                      |                                      |
| EDUCATIONAL PROGRAM                                                                                                                                                                          |                                      | LOCATION                             |
| AND THAT THIS SCHOOL WAS APPROVED BY THE REGISTERING AUTHORITY AT THE TIME THIS PROGRAM WAS COMPLETED.                                                                                       |                                      |                                      |
| REGISTRATION WAS OBTAINED BY                                                                                                                                                                 | <input type="checkbox"/> EXAMINATION | <input type="checkbox"/> ENDORSEMENT |
| TITLE ASSIGNED                                                                                                                                                                               |                                      |                                      |

|                                                                |                                             |
|----------------------------------------------------------------|---------------------------------------------|
| <b>INITIAL REGISTRATION WAS ISSUED BY THIS JURISDICTION ON</b> |                                             |
|                                                                |                                             |
| ISSUE DATE (YYYY-MM-DD)                                        | NUMBER                                      |
| <b>CURRENT LICENCE TO PRACTICE NURSING WAS ISSUED ON</b>       |                                             |
|                                                                |                                             |
| ISSUE DATE (YYYY-MM-DD)                                        | EXPIRY DATE OF CURRENT LICENCE (YYYY-MM-DD) |

NOTE: If you answer YES to any of the questions below, attach an explanation

|                                                                                                                                                                              |                              |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. IS THIS PERSON CURRENTLY UNDER REVIEW/INVESTIGATION BY YOUR REGULATORY BODY? IF YOU ARE UNABLE TO ANSWER, PLEASE CHECK THIS BOX <input type="checkbox"/>                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. HAS THIS PERSON EVER RECEIVED ANY TYPE OR FORM OF DISCIPLINARY ACTION ON THEIR REGISTRATION OR LICENCE IN YOUR JURISDICTION SUCH AS REVOCATION, SUSPENSION, OR REPRIMAND? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. IF YOU ANSWERED YES TO #2, HAS THE REGISTRATION/LICENCE BEEN REINSTATED?                                                                                                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. HAS THIS PERSON EVER HAD ANY CONDITIONS OR RESTRICTIONS IMPOSED ON THEIR LICENCE?                                                                                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. IF YOU ANSWERED YES TO #4 ABOVE, HAVE CONDITIONS OR RESTRICTIONS IMPOSED ON THEIR LICENCE BEEN REMOVED?                                                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

|                             |                           |                    |               |
|-----------------------------|---------------------------|--------------------|---------------|
| REGISTRATION/LICENSURE EXAM | DATE WRITTEN (YYYY-MM-DD) | NUMBER OF WRITINGS | SCORE RESULTS |
|                             |                           |                    |               |

|      |                   |                     |
|------|-------------------|---------------------|
| SEAL |                   |                     |
|      | DATE (YYYY-MM-DD) | POSITION            |
|      |                   |                     |
|      | SIGNATURE         | NAME (PLEASE PRINT) |