

SECTION 5. SCREENING QUESTIONS

Answer the following questions by placing a tick (✓) in the appropriate box. If you answer "yes" to any of these questions you are required to provide complete details **on a separate sheet of paper** and attach to this form.

		Yes	No
1.	Do you hold licensure or are you registered (active, inactive, or expired) to practice in any other jurisdiction?		
2.	Have you ever withdrawn an application for registration, had an application denied or refused, or agreed not to reapply for registration in another country?		
3.	Has any disciplinary action been taken against you by any regulatory authority?		
4.	Have you been convicted, found guilty, or pleaded guilty or nolo contendere to any offence?		
5.	Do you have a physical or medical condition that currently impairs your ability to practice nursing?		
6.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs?		

SECTION 6 ACCOMPANYING DOCUMENTS

The following documents must accompany your application:

- a) Notarized copy of your initial license or certificate of registration
- b) Notarized copy of a current nursing license which includes an expiry date
- c) Notarized copy of Nursing Diploma/Degree and other qualifications
- d) Copy of document signifying name change if any documents are in different names
- e) Copy of IELTS or TOEFL examination result if English is not your first language
- f) Character reference from non-relative who has known you for at least three years
- g) Registration fee of U.S. \$ 28.00 in the form of a Cashier's cheque, a Bank draft or a Money Order made payable to the Accountant General. Do not send cash or personal cheque

SECTION 7. SIGNED STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements may result in the revocation of my registration.

Signature: _____ **Date** _____

Witness: _____ **Seal**

Must be a Notary Public



**BERMUDA NURSING COUNCIL
MINISTRY OF HEALTH**

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VERIFICATION OF NURSE REGISTRATION FORM

PART A: Applicant to Complete

Please complete Part A of this form and forward a copy to each regulatory body in which you have been registered as well as the regulatory body in which you are currently registered.

Please Print:

Last Name _____

Forenames _____

Former Name _____ Date of birth: _____

Registration Date: _____ Registration #: _____

I am applying for nurse registration in Bermuda and a record of my nurse registration is required.

Signature _____ Date _____

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PART B: Regulatory Body to Complete

Please complete Part B of this form and mail it to the Bermuda Nursing Council at the address above.

Please Print

Name of Regulatory Body: _____

Name of Registrant: Last Name _____

Forenames _____

Former Name _____ Date of Birth _____

Registration # _____ Date of Issue: _____ Status: _____

Registration Granted (title): _____

Registered by (Please circle one) Examination Endorsement

a) Has the above named person's registration ever been denied, suspended, revoked, or under investigation? Yes No

b) Have any special conditions been placed on his/her practice? Yes No

c) Are there any factors known to you that would impact on this registrant's fitness to practice? Yes No

If Yes to any of the above, please attach an explanatory note.

Name of person completing this form _____

Title _____ Signature _____ Date _____

Authority Seal

