THE NURSING COUNCIL OF JAMAICA

Nurses and Midwives Act, 1964
50 Half Way Tree Road
Kingston 5
Jamaica W.I.

APPLICATION FORM FOR VERIFICATION/VALIDATION OF LICENSURE

PLEASE PRINT OR TYPE

NAME OF APPLICANT: _____
FIRST NAME MIDDLE LAST NAME

NAME ON REGISTER: _____
FIRST NAME MIDDLE LAST NAME

NURSING COUNCIL REGISTRATION **RGN** ☐ **RM** ☐ **RMN** ☐ **EAN** ☐

REGISTRATION NUMBER _____

DATE OF BIRTH: (DD/MM/YYYY) _____

MARITAL STATUS: _____

TRN #: _____

TRAINING INSTITUTION: _____

INSTITUTION ADDRESS: _____

GRADUATION DATE _____ **EXAM DATE** _____

PERIOD OF TRAINING: **From:**_____ **To:** _____

NO. OF TIMES YOU SAT THE EXAM: _____

PLACE OF EMPLOYMENT _____

HAVE YOU RELICENCED? _____

WHAT IS YOUR EXPIRY DATE? _____

CONTACT # _____

CREDENTIALS (check as appropriate) **Certificate** ☐ **Diploma** ☐ **Degree** ☐

VERIFICATION TYPE: **Regular (21 working days processing time)** ☐

Express (7 working days processing time) ☐

PAYMENT TYPE: **Certified Cheque** ☐ **Money Order** ☐ **Cash** ☐ **AMOUNT PAID $**_____

FEES:	**LOCALLY TRAINED**	**Regular: US$ 150***	**Express: US$ 200***
	TRAINED ABROAD	**Regular: US$ 200***	**Express: US$ 250***

or the Jamaican equivalent at the current rate

N.B. VERIFICATION FEES PAID TO THE COUNCIL ARE NON-REFUNDABLE

DECLARATION
I certify that the information given by me in this application is true to the best of my knowledge

NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

DATE: DD/MM/YYYY: _____

Please return this completed form to the Nursing Council of Jamaica,
50 Half Way Tree Road, Kingston 5, Ja. WI
Telephone Numbers (876)929-5118, (876)960-0823
Email address: nurs@cwjamaica.com