THE NURSING COUNCIL OF JAMAICA

Nurses and Midwives Act, 1964
50 Half Way Tree Road
Kingston 5, Jamaica W.I.
Email: overseas-inquiries@nursingcouncil.org.jm

APPLICATION FORM FOR VERIFICATION/VALIDATION OF LICENSURE

PLEASE PRINT OR TYPE

NAME OF APPLICANT: ____
FIRST NAME MIDDLE NAME LAST NAME

NAME WHEN REGISTERED: ____
FIRST NAME MIDDLE NAME LAST NAME

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

REGISTRATION NUMBER: ____

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

MARITAL STATUS: ____

TRN #: ____

TRAINING INSTITUTION: ____

INSTITUTION ADDRESS: ____

PERIOD OF TRAINING: FROM: ____________________ TO: ____________________

GRADUATION DATE (DD/MM/YYYY): ____________________ EXAM DATE: ____________________

NO. OF TIMES YOU SAT THE EXAM: ____________________

PLACE OF EMPLOYMENT: ____

HAVE YOU RELICENCED? ____________________ IF YES, BRL TRACKING #: ____________________

WHAT IS YOUR EXPIRY DATE (DD/MM/YYYY)? ____

CONTACT #: ____________________ EMAIL: ____________________

CREDENTIALS (CHECK AS APPROPRIATE): CERTIFICATE ☐ DIPLOMA ☐ DEGREE ☐

PLEASE SEE NEXT PAGE

Have you ever been the subject of any proceeding concerning the practice of nursing or midwifery, since being issued a licence? ☐ Yes ☐ No **(If yes, please explain)**

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Are you currently the subject of any legal proceedings, inquiry, investigation for professional misconduct, incompetence, incapacity or any similar investigation concerning the practice of nursing or midwifery, since being issued a licence? ☐ Yes ☐ No **(If yes, please explain)**

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PROCESSING TIMES & FEES:

- Locally trained Regular: 21 working days – **US$150**(or Jamaican equivalent) ☐
- Trained abroad Regular: 21 working days – **US$200**(or Jamaican equivalent) ☐

Please be advised that in addition to processing fees -the courier fee is ***US$50*** (optional) ☐

PAYMENT METHOD:

Debit/Credit Card ☐ Online Transfer ☐ Certified Cheque ☐ International Money Order ☐

Amount Paid $ ____________________

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 send this completed form along with the agency's form/address and evidence of payment to the Nursing Council of Jamaica.