



**SECTION B. To be completed by the original Licensing Authority only.**

**ATTENTION: To be sent directly to The Registrar, Nursing Council of Jamaica**

1. Name of Applicant when registered

[Empty text box for Name of Applicant]

Date of Birth: [Day] [Month (Jan, Feb., Mar...)] [Year]

License/Registration Number  
[Empty text box]

Original issue date of licensure/registration  
[Day] [Month (Jan, Feb., Mar...)] [Year]

Expiration date (If does not expire, state)  
[Day] [Month (Jan, Feb., Mar...)] [Year]

2. Current License/Registration Status

Active    Inactive    Expired

Has the licence been subject to any of the following actions?

Revocation    Suspension    Surrender    Restriction

3. Is the applicant presently facing, or has faced any of the following disciplinary measures? *If yes, provide explanation/outcome*

Professional misconduct    Incapacity    Incompetence    Professional negligence    Malpractice  
 Reprimand    Probation    Other \_\_\_\_\_ (Please state)

4. Has the applicant ever been refused licensure/registration to practice as a nurse/midwife in your or any other jurisdiction?

Yes    No (if yes, please attach an explanation)

5. Type of Professional Education Programme completed by the Applicant

Doctoral    Master's    Baccalaureate    Associate    Diploma    Certificate    Other \_\_\_\_\_

Programme

Registered General Nurse    Registered Midwife    Registered Mental Health Nurse  
 Registered Paediatric Nurse    Enrolled Assistant Nurse    Licensed Practical Nurse    Other \_\_\_\_\_

6. Was the nursing/midwifery programme recognized or approved by the regulatory body in the country which the programme was completed?  Yes    No

Year of accreditation [Empty text box]

7. Registration was obtained by: (Please check applicable box)

Examination    Endorsement/review of licence    Other (Please specify) \_\_\_\_\_

If exam, state the name of the examination [Empty text box]

If endorsement, state the country/jurisdiction where the applicant first acquired the licence to practise. [Empty text box]

Name and Address of Licensing Authority

[Empty text box for Name and Address of Licensing Authority]

Email Address: [Empty text box]   Website: [Empty text box]

Telephone: [Empty text box]   Fax: [Empty text box]



**I hereby certify that the information above is true and taken directly from the applicant's registration record.**

Name of Authorised Official \_\_\_\_\_

Title of Authorised/Registration Official: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_