

THE NURSING COUNCIL OF JAMAICA

Nurses and Midwives Act, 1964

For Official Use Only NCJ REF No.

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ALL COMMUNICATIONS SHOULD BE ADDRESSED TO THE REGISTRAR

Request for Licence/Registration Validation (Internationally Trained)

ATTENTION: 1. Complete a separate form for <u>each</u> licence to be validated.

2. The completed application must be sent <u>directly</u> from the Licensing/Registration Authority to the Nursing Council of Jamaica.

SECTION A. This section is to be completed by the **Applicant** in the English Language.

Curr	ent Name:							
	e when Registered: fferent from the above)		Country::					
Prof Title	essional Nursing/Midwifery :		Date of Birth: (dd/mm/yyyy					
Lice	nce/Registration Number:		Expiry date:: dd/mm/yyyy					
Ema	il address:		Telephone::					
Mail	ing address:							
1.	Have you ever been th	Nursing Midwifery	□ Yes □ Yes	□ No □ No				
	If yes, check all that a							
	□ Inquiry/investigation □ Incompetence	□ Incapacity □ Professional □ Suspension □ Other	misconduct					
2.	Are you currently or have you ever been the subject of any criminal or legal proceedings? \Box Yes \Box No							
	(If you answered yes, to any of the above, provide a brief explanation)							
_								
3. Do you meet your licence or registration authority's standards for continuing competency?								
AUTHORITY TO RELEASE INFORMATION I. (complete name of applicant) hereby authorise the (name of regulatory authority) to provide the requested information and any supporting documents to the Nursing Council of Jamaica.								

			Day	Month (Jan, Feb., Mar)	Year
Signature of Applicant:	1	Date:			

SECTION B. To be completed by the original <u>Licensing Authority</u> only.

ATTENTION: To be sent <u>directly</u> to The Registrar, Nursing Council of Jamaica

1. Name of Applicant when reg	Name of Applicant when registered				Day	Year		
				Date o Birth				
	Original issue date of licensure/registr				Expiratior	n date (If does not expir	re, state)	
License/Registration Number	Day	Month (Jan, F	Feb., Mar)	Year	Day	Month (Jan, Feb., Mar	. Year	
2. Current License/Registration	n Status	Has the lie	cence been su	bject to any	of the fo	bllowing actions?		
Active Inactive Exp	□ Active □ Inactive □ Expired □ Revoca			ension	🗌 Suri	render 🗌 Res	triction	
	☐ Incapacity ☐ Probation	Incompete Other	ence 🗌 Pr	ofessional neg	ligence	☐ Malprac (P	tice lease state)	
	s, please attach							
5. Type of Professional Educa	tion Programn	ne completed	l by the Applica	ant				
□ Doctoral □ Master's	Baccalaureate		ciate 🗌 Dip	Ioma 🗆 (Certificate	e 🗌 Other		
Programme								
Registered General Nurse	Registered General Nurse Registered Midwife Registered Mental Health Nurse							
Registered Paediatric Nurse	Enrolled Assis	tant Nurse	Licensed Prac	tical Nurse		Other		
 Was the nursing/midwifery probody in the country which the Registration was obtained by: 	e programme wa	as completed			Year	of accreditation		
-								
Examination Endorsement/review of licence If exam, state the name of the examination			Other (Plea	se speciry)				
If and areamont state, the av	ouptru/iuriodictic	n whore the	opplicant first					
If endorsement, state the co acquired the licence to pract			applicant inst					
Name and Address of Licens	ing Authority							
Email Address: Telephone:			Website:					
			Fax:					
AFFIX OFFICIAL ap								
SEAL/STAMP HERE Name of Authorised Official								
Tit	Official:							
Sig		Date:						