



BERMUDA NURSING COUNCIL

MINISTRY OF HEALTH & FAMILY SERVICES
P.O. Box HM 674, Hamilton HM CX, Bermuda
Telephone: (441) 236-0224 Ext. 3409
Fax: (441) 232-1823

REGISTRATION OF NURSES **APPLICATION FORM**

- Mr.
- Mrs.
- Ms.

NAME:.....
(Print) FIRST MIDDLE LAST (Nee) Maiden Name

In support of any application I present the following details:

ADDRESS:.....
.....

Telephone Number () Fax: ()

DATE OF BIRTH: Day..... Month..... Yr.

PLACE OF BIRTH:..... PRESENT NATIONALITY:.....

PRIMARY LANGUAGE:.....

NURSING INSTITUTION:.....

INITIAL & OTHER REGISTRATION/LICENCE:

NUMBER:..... DATE ISSUED:..... PLACE ISSUED:.....

NUMBER:..... DATE ISSUED:..... PLACE ISSUED:.....

NUMBER:..... DATE ISSUED:..... PLACE ISSUED:.....

Nursing qualifications held, stating place and date of Awards:

.....
.....
.....

I, the undersigned, wish to be admitted to the REGISTER of nurses as a :

(Tick appropriate box). PLEASE NOTE: FEE IS \$26.00 FOR **EACH** CATEGORY.

- REGISTERED NURSE (General)
- PSYCHIATRIC NURSE (Specify Branch).....

NOTE: CONSIDERATION WILL NOT BE GIVEN TO APPLICANTS WHO HAVE FAILED TO SUBMIT THE REQUIRED FEE AND ALL OF THE REQUIRED DOCUMENTS.

Prospective employer in Bermuda.....

Signature of Applicant.....

Date of Application.....

FEE RECEIVED:
DATE REGISTERED:
REGISTRATION NUMBER:

