College of Registered Nurses of Newfoundland & Labrador

FORM 1

NURSE PRACTITIONER (NP) APPLICATION FOR LICENSURE ELIGIBILITY

1. Personal Information

Surname	Given Name(s)	Maiden and/or Other Surname(s)
Mailing Address		Postal Code
Telephone (H)	Telephone (B)	Email Address
CRNNL RN Registration Number	Expiry Date of RN Practicing License (Y/M/D)	

Other RN Registrations:

List all jurisdictions where you hold current RN registration/licensure.

Number	Province/State/Country	Date Issued (Y/M/D)	Expiry Date

Other NP Registrations:

List all jurisdictions where you hold current NP registration/licensure (if applicable).

Number	Province/State/Country	Date Issued (Y/M/D)	Expiry Date

2. Nurse Practitioner Education

Nurse Practitioner Program

School: _____

Address: _____

Date of Completion: _____ (Year/Month/Day)

Program of Study: ☐ Family All Ages ☐ Adult ☐ Pediatric

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3. Nurse Practitioner Employment

List current NP employment (if applicable). Attach separate sheet if needed

Employer

Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Employment Date: _____
(Year/Month/Day)

Second Employer

Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Employment Date: _____
(Year/Month/Day)

OR

If in Independent Practice/Self-Employed

Nurse's Business Address: _____

Phone Number: _____ **Fax Number:** _____

Consultative Physician's Name: _____

Address: _____

4. Controlled Drugs and Substances Requirements

All NPs are required to complete the following:

- A prescribing Controlled Drugs & Substance (CDS) course approved by CRNNL.
- Government of Newfoundland and Labrador Tamper Resistant Prescription Pad Program (TRPPP) declaration.

For information on approved CDS courses and information regarding TRPPP contact registration@crnnl.ca
Link to the TRPPP website: http://www.health.gov.nl.ca/health/prescription/hcp_tamperresistantdrugpad.html

Have you completed the Controlled Drugs & Substances requirements? **Yes** ☐ **No** ☐

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5. Choosing Wisely NL

Quality of Care Newfoundland and Labrador is a provincial initiative aimed at improving health care in our province by looking for new ways to make sure people get the care they need, when they need it. *Quality of Care NL* works with Choosing Wisely Canada to implement their recommendations on reducing unnecessary care here in Newfoundland and Labrador. These projects are known as *Choosing Wisely NL* projects.

Through partnership with CRNNL, Nurse Practitioners can receive their personal prescribing information directly from Quality of Care NL/Choosing Wisely NL by completing the question below to provide their consent.

Once licensed as an NP with CRNNL do you consent to receive your personal prescribing information directly from Quality of Care NL/Choosing Wisely NL? ☐ **Yes** ☐ **No**

Note: campaign information will be sent to the e-mail address you provide to CRNNL during registration.

6. Declaration

I _____ understand that I am required by the RN Regulations (2013) to immediately update
Name

CRNNL should any of the information provided above change. I hereby make application for a licensure as a

nurse practitioner in _____ and declare that the above information is true and correct.
Family All Ages/Adult/Pediatrics

_____ _____

Date Signature of Applicant

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FORM 2

VERIFICATION OF NURSE PRACTITIONER EDUCATION

Applicants who are new NP graduates and have not established NP licensure in another jurisdiction will complete section A and forward this request for verification to the school of nursing where the nurse practitioner education program was completed. If new graduate from Memorial University of Newfoundland NP program or NP licensed in another Canadian jurisdiction this form is **not** required.

Section A: For Applicant

I, _____
Given Name Surname Maiden or other surname(s)

Graduated from the _____ nurse practitioner program
School

on _____.
Date

_____ _____
Date Signature of Applicant

Section B: VERIFICATION OF NURSE PRACTITIONER PROGRAM COMPLETION

To be completed by the designated authority for the nurse practitioner education program and forwarded directly to CRNNL along with a copy of the applicant's **official transcript**.

Note: For applicants educated outside Canada, attached official transcripts and a copy of detailed **course descriptions & curriculum plan** with the corresponding number of clinical & theoretical hours. Documents must be forwarded directly to CRNNL from the applicant's school/university.

This is to certify that _____
Given Name Surname Maiden or other surname(s)

was admitted to _____ Nurse Practitioner Program
School

on _____ and completed the program on _____. The program of study was
Date Date

in _____ and the length of the program was _____ months. This program was an
Family All Ages/Adult/Pediatrics

approved program at the time the program was completed: _____
Yes/No

_____
Signature

SEAL

_____
Title

_____
Date

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FORM 3

VERIFICATION OF NURSE PRACTITIONER REGISTRATION/LICENSURE

The applicant will complete section A and forward this part to the jurisdiction(s) where the nurse established registration/licensure as a nurse practitioner. A verification of registration/licensure is required for all jurisdictions where the applicant holds registration/licensure as a NP.

Section A: For Applicant

I, _____
Given Name Surname Maiden or other surname(s)

graduated from the _____ nurse practitioner program
School

on _____.
Date

I established initial registration as a Nurse Practitioner on _____ under number _____
Date

_____ _____
Date Signature of Applicant

Section B: FOR REGISTERING AUTHORITY

To be completed by the designate authority that granted Nurse Practitioner registration.

This is to verify that _____
Given Name Surname Maiden or other surname(s)

1. Graduated from _____ Nurse Practitioner Program on _____.
School Month/year

   The program was an approved program at the time the program was completed: _____
Yes/No

   OR

2. Registered/Licensed in the NP Stream of Practice of _____ on _____.
Family All Ages/Adult/Pediatric Date

   Registration as a nurse practitioner was granted on _____ under number _____.
Date

   Date license was last issued _____ Date license expires/ed _____
Date Date

   Has this NP license ever been suspended or revoked or under review/investigation? _____ _____
   (If yes, please indicate the reason on the reverse side) Yes/no Date

   Has this license been reinstated? _____ _____
Yes/no Date

   Are there conditions or restrictions on the applicants NP registration or license? _____(if _____
   yes, please indicate the reason on the reverse side) Yes/no Date

SEAL

_____ _____
Executive Director or Director of Registration Date

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FORM 4

STATEMENT FROM CURRENT/MOST RECENT EMPLOYER FOR NURSE PRACTITIONER LICENSURE

The applicant will complete Section A and forward request to the Director of Nursing OR Director of Human Resources at your current/most recent place of employment for completion. References include all NP employers **within the last five years** starting with the most recent employer. (Please make additional copies as required)

Section A: For Applicant

Name: _____
Given Name Surname Maiden or other Surname(s)

Telephone #: _____ Email address: _____

Dates of Employment: _____ to _____ Employer # _____
(If applicable)

I hereby give consent for release of information as requested by CRNNL.

_____ _____
Date Signature of Applicant

Section B: Employer

The above-named applicant is applying for nurse practitioner licensure with the College of Registered Nurses of Newfoundland & Labrador (CRNNL). Please complete the following statements in relation to the applicant's employment as a Nurse Practitioner. Please return the completed form directly to CRNNL at the address noted above. A faxed/email response is acceptable.

Employer Name: _____

Employer Address: _____

Dates of Employment: _____

Number of hours practiced nursing during the applicable following periods:

April 2018-March 2018	April 2019-March 2020	April 2020-March 2021	April 2021-March 2022
_____	_____	_____	_____

Classification/Status/Position: _____

Performance: Above Average: _____ Satisfactory: _____ Unsatisfactory: _____

COMMENTS: _____

_____

Would you rehire? Yes _____ No _____

If NO, state reason: _____

Reason for leaving: _____

Do you recommend employment? Yes _____ No _____ Do you recommend licensure? Yes _____ No _____

Signature: _____ **Date:** _____

Position: _____