College of Registered Nurses of Newfoundland & Labrador

1033 Topsail Rd | Mount Pearl | NL | Canada | A1N 5K3 | c r n n l . c a

The applicant will complete Section A only and forward this form to the registered authority which granted registration for completion of Section B. If registered in more than your original or one other jurisdiction, you may copy and forward to all jurisdictions.

Section A: Applicant Information

I, _____ _____ _____
Surname Given Name Maiden Name (if applicable)

born on _____ graduated from _____
Day/Month/Year School of Nursing

in _____ _____ _____ in _____
City Province/State Country Month/Year

I was originally registered in _____ in _____ under number _____
Province/State/Country Month/Year

I was registered in your jurisdiction in _____ under number _____
Month/Year

My present address is _____
Street Address

_____ _____ _____ _____
City Province/State Country Postal Code

E-mail address _____

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

_____ _____
Date Signature of Applicant

Section B is to be completed by the registering authority and forwarded directly to the College of Registered Nurses of Newfoundland & Labrador.

Section B: Verification From Registering Authority

Acting on behalf of the _____
Authority which granted registration

I do hereby certify that _____
Name of Applicant

was issued a certificate of registration as a ☐ Registered Nurse ☐ Nurse Practitioner ☐ Registered Psychiatric Nurse ☐ Other _____

in this jurisdiction on _____ and number _____
Date

by ☐ Examination ☐ Certification _____ _____
Date license was issued Date license expires/ed

	Yes	No	Date
Has this license ever been suspended or revoked or under review/investigation? *(if Yes, please indicate the reason on the reverse side)*	☐	☐	_____
If Yes, has this license been reinstated? (leave blank if not applicable)	☐	☐	_____
Are there conditions or restrictions on the applicant's registration or licensure? *(If Yes, please indicate the reason on the reverse side)*	☐	☐	_____

Applicant's current membership status: _____

Insofar as is known by this Authority, the applicant is eligible for registration Yes/No _____

Nurse Registration Examination Results:
Examination name: _____
Language of exam: _____ Number
of attempts: _____

Other Registrations (if more than 2 please continue on reverse)	Province/Country	Date	Number
	_____	_____	_____
	_____	_____	_____

SEAL

_____ _____
Executive Director or Director of Registration Date