REGISTRATION/LICENSURE VERIFICATION

☐ LPN | ☐ RN | ☐ NP (CHECK ALL THAT APPLY)

NSCN APPLICATION NUMBER (IF KNOWN): _____

300 - 120 Western Parkway
Bedford, Nova Scotia B4B 0V2
Tel: 902-444-6726
Toll-free (NS) 1-833-267-6726
fax: 902-377-5188
registration@nscn.ca

SECTION A - APPLICANT

Complete Section A then forward to the registering/licensing authority requesting they verify your status by completing Section B.

SURNAME	GIVEN NAMES	BIRTH/FORMER NAME
SCHOOL OF NURSING AND LOCATION		DATE OF BIRTH (YYYY-MM-DD)
YEAR OF GRADUATION	YEAR REGISTERED	REGISTRATION NUMBER
SIGNATURE		DATE (YYYY-MM-DD)

SECTION B – REGISTERING/LICENSING AUTHORITY

Please return completed form by mail directly to the Nova Scotia College of Nursing at the address above.

ACTING ON BEHALF OF THE		
REGISTERING AUTHORITY		
I DO HEREBY CERTIFY THAT		
SURNAME	GIVEN NAMES	
BIRTH/FORMER NAMES	DATE OF BIRTH (YYYY-MM-DD)	
☐ BY CHECKING THIS BOX, I CONFIRM THAT THE APPLICANT NAMED IN SECTION A AND THE INDIVIDUAL WE, THE REGULATORY BODY, HAVE IDENTIFIED IN SECTION B ARE THE SAME PERSON.		
A GRADUATE OF		
EDUCATIONAL PROGRAM	LOCATION	
AND THAT THIS SCHOOL WAS APPROVED BY THE REGISTERING AUTHORITY AT THE TIME THIS PROGRAM WAS COMPLETED.		
REGISTRATION WAS OBTAINED BY	☐ EXAMINATION	☐ ENDORSEMENT
TITLE ASSIGNED		

INITIAL REGISTRATION WAS ISSUED BY THIS JURISDICTION ON	
ISSUE DATE (YYYY-MM-DD)	NUMBER
CURRENT LICENCE TO PRACTICE NURSING WAS ISSUED ON	
ISSUE DATE (YYYY-MM-DD)	EXPIRY DATE OF CURRENT LICENCE (YYYY-MM-DD)

NOTE: If you answer YES to any of the questions below, attach an explanation

1. IS THIS PERSON CURRENTLY UNDER REVIEW/INVESTIGATION BY YOUR REGULATORY BODY? IF YOU ARE UNABLE TO ANSWER, PLEASE CHECK THIS BOX ☐	☐ YES	☐ NO
2. HAS THIS PERSON EVER RECEIVED ANY TYPE OR FORM OF DISCIPLINARY ACTION ON THEIR REGISTRATION OR LICENCE IN YOUR JURISDICTION SUCH AS REVOCATION, SUSPENSION, OR REPRIMAND?	☐ YES	☐ NO
3. IF YOU ANSWERED YES TO #2, HAS THE REGISTRATION/LICENCE BEEN REINSTATED?	☐ YES	☐ NO
4. HAS THIS PERSON EVER HAD ANY CONDITIONS OR RESTRICTIONS IMPOSED ON THEIR LICENCE?	☐ YES	☐ NO
5. IF YOU ANSWERED YES TO #4 ABOVE, HAVE CONDITIONS OR RESTRICTIONS IMPOSED ON THEIR LICENCE BEEN REMOVED?	☐ YES	☐ NO

REGISTRATION/LICENSURE EXAM	DATE WRITTEN (YYYY-MM-DD)	NUMBER OF WRITINGS	SCORE RESULTS

SEAL		
	DATE (YYYY-MM-DD)	POSITION
	SIGNATURE	NAME (PLEASE PRINT)