Nurses Association OF NEW BRUNSWICK Association des infirmières et infirmiers DU NOUVEAU-BRUNSWICK

165, rue Regent Street, Fredericton N.B., Canada, E3B 7B4

PASSPORT PHOTO

Date of receipt stamp (for office use only)

INTERNATIONALLY EDUCATED NURSE APPLICATION FOR REGISTRATION

A. PERSONAL INFORMATION

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Current address: _____
Apt # Street Name

_____
City State / Province Postal Code/ Zip code Country

Telephone number: (_____) _____ (_____) _____
Home Cell phone

E-Mail: _____

Gender: ÿ Female ÿ Male **First language:** ÿ English ÿ French ÿ Other

Date of birth _____/_____/_____ **Country of birth:** _____
Day Month Year

B. INITIAL NURSE EDUCATION

School of Nursing: _____
Print full name of school

Location: _____
City Country

Length of program: _____Years **Year of graduation:** _____

Other nursing education: _____

C. NURSING REGISTRATION STATUS

Registration	Province/State/ Country	Registration Number	Effective Date	Expiry Date
Initial Registration				
Other Registration				
Other Registration				

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D. APPLICANT DECLARATION

Have you previously applied for registration in another Canadian province/territory?

ÿ Yes ÿ No Specify: _____

Have you had a Nursing Competence Assessment done through another Canadian province/territory?

ÿ Yes ÿ No Specify: _____

Have you ever been denied registration in another Canadian province/territory?

ÿ Yes ÿ No Specify: _____

Have you written the Canadian Registered Nurse Examination or the Quebec Examination?

ÿ Yes ÿ No If yes, please indicate locations and number of times written: _____

Has your registration ever been suspended, revoked, or subjected to conditions or restrictions?

ÿ Yes ÿ No Specify: _____

Have you ever been charged with or convicted of a criminal offence?

ÿ Yes ÿ No Specify: _____

Location and anticipated place of employment:_____

E. PAYMENT

A processing fee of $452.00 in Canadian funds must be enclosed with this application.

I am paying by €Certified cheque € Money order €Visa € MasterCard €Cash

Credit card users, please complete the following information:

Card number: ½__|__|__|__½__|__|__|__½__|__|__|__½__|__|__|__½ Expiry date ½__|__½ __|__½

_____ _____
Name of cardholder Authorizing signature

Forward your birth certificate (and marriage certificate, if applicable). These are required in order to verify your records. **We can only accept originals or copies certified by a notary public**. Originals will be returned to you.

I hereby make application for registration with the NANB and declare the above statements to be true and complete. I understand that in New Brunswick, it is illegal to practise nursing without a valid registration certificate.

I understand NANB may collect, use and disclose personal information to carry out its mandate under the Nurses Act to protect the public, for professional regulation, research, statistical, educational, planning and nursing database purposes .

_____ _____
Date Signature

Return signed form to NANB along with the processing fee.

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LANGUAGE

Applicants whose mother tongue is neither English nor French are required to submit proof of competency in one of these languages before being eligible to apply for registration. Results must be forwarded directly to the Nurses Association of New Brunswick (NANB). The following language tests have been approved.

	Name of Test	Minimum Passing Score	Contact Information
English Language			
1	TOEFL (Test of English as a Foreign Language)	550 - paper test 213 - computer test	www.toefl.org email: toefl@ets.org 1-877-863-3546 (US & Canada only) 1-609-771-7100 (NANB's institution code is "9201")
	TSE (Test of Spoken English)	50	www.lsa.umich.edu/eli/melab email: melabelium@umich.edu 1-866-696-3522 or 1-734-763-3452
2	IELTS **Academic Version** (International English Language Testing System)	6.5 - overall score 7.0 - spoken English	www.ielts.org
3	MELAB (Michigan English Language Assessment Battery)	83 - overall score 3 - spoken English	www.lsa.umich.edu/eli/melab email: melabelium@umich.edu 1-866-696-3522 or 1-734-763-3452
4	CELBAN (Canadian English Language Benchmark Assessment for Nurses)	8 – speaking 9 - listening 8 – reading 7 - writing	www.celban.org email: celas@rrc.mb.ca 1-204-945-0588
5	TOEIC (Test of English for International Communication) *This test does not include spoken section, must be combined with TSE (Test of Spoken English)	800	www.toeic.ca email: info@toeic.ca 1-800-615-8666 (US & Canada only) 1-613-542-3368
FRENCH LANGUAGE			
1	TFI (Test de français international)	438	www.tfi.info courriel: info@toeic-europe.com

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DECLARATION OF EMPLOYMENT AND REFERENCES

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Date of birth: _____/_____/_____ **Country of birth:** _____
Day Month Year

Please provide all employers over the past five years, including the length of employment, and reason for leaving. The names and position titles of **two references are required from your last nursing employer** who will be submitting professional references to NANB.

Period of Employment	Name and Address of Employer	Your Position	Reason for Leaving	Name & Position of the Reference

_____ _____
Date Applicant's Signature

To be returned by applicant to NANB.

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VERIFICATION OF INITIAL REGISTRATION

SECTION A (*To be completed by applicant and forwarded to the Regulatory Body which granted your initial nursing registration.)*

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Current address: _____

_____
City State / Province Country

Date of birth _____/_____/_____ **My registration number in your Jurisdiction** _____
Day Month Year

Graduated from: _____ **Date of graduation** _____/_____/_____
School of Nursing Day Month Year

_____ _____
Date Signature

SECTION B (*To be completed by the Nursing Regulatory Body and forwarded directly to NANB.)*

Acting on behalf of _____ **, I do hereby certify that**
Regulatory Body
_____ **a graduate of** _____
Name of applicant School of nursing

located in _____ **was issued a certificate of registration as a**
City Province/State/Country

Registered Nurse on _____/_____/_____**, bearing number** _____
Day Month Year

The certificate was obtained by: ÿ Examination
ÿ Endorsement

EXAMINATION INFORMATION
Registration Examination: ÿ NCLEX ÿ Other:
Passing score: _____
Number of times written:

The applicant's current registration status with this authority _____**Valid until** _____

The applicant's registration / membership status for the past five years:

Year	Status
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is this registration presently suspended, revoked, subjected to conditions or restrictions, or under investigation? ÿ Yes ÿ No

_____ _____
Date Printed name and Signature

Official Seal/Stamp

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VERIFICATION OF CURRENT REGISTRATION

SECTION A (*To be completed by applicant and forwarded to the Regulatory Body which granted your current nursing registration.)*

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Current address: _____

_____
City State / Province Country

Date of birth _____/_____/_____ **My registration number in your Jurisdiction** _____
Day Month Year

Graduated from: _____ **Date of graduation** _____/_____/_____
School of Nursing Day Month Year

_____ _____
Date Signature

SECTION B (*To be completed by the Nursing Regulatory Body and forwarded directly to NANB.)*

Acting on behalf of _____**, I do hereby certify that**
Regulatory Body

_____ **a graduate of** _____
Name of applicant School of nursing

located in _____ **was issued a certificate of registration as a**
City Province/State/Country

Registered Nurse on _____/_____/_____**, bearing number** _____
Day Month Year

The certificate was obtained by: ÿ Examination

ÿ Endorsement

EXAMINATION INFORMATION
Registration Examination: ÿ NCLEX ÿ Other:
Passing score: _____
Number of times written:

The applicant's current registration status with this authority _____**Valid until** _____

The applicant's registration / membership status for the past five years:

Year	Status
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is this registration presently suspended, revoked, subjected to conditions or restrictions, or under investigation? ÿ Yes ÿ No

_____ _____
Date Printed name and Signature

Official Seal/Stamp

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PROFESSIONAL REFERENCE

APPLICANT INFORMATION (*To be completed by applicant and forwarded to current or most recent nursing employer.)*

Name of applicant: _____ Maiden/ former name(s): _____

Name of Reference: _____ Position title: _____

EMPLOYER REFERENCE (*To be completed by applicant's Supervisor/Employer)*

Dates employed from _____ to _____ Status: ÿ Full time ÿ Part-time

Characteristics	Very Good	Average	Fair	Poor
A. Personal Qualities				
1) initiative				
2) motivation				
3) reliability				
4) maturity				
B. Relationship with				
1) peers				
2) clients				
3) co-workers				
3) other professionals				
C. Nursing Potential				
1) ability to organize work				
2) ability to apply knowledge				
3) ability to meet the standards of care				
4) leadership				

On the basis of past performance, would you re-employ this nurse? ÿ Yes ÿ No

If no, please elaborate: _____

_____

Is this reference based on personal knowledge? ÿ Yes ÿ No **or personnel file?** ÿ Yes ÿ No

Printed name: _____ **Signature:** _____

Title: _____ **Agency:** _____

Address: _____

Date: _____**Telephone number:** (_____)_____

This reference must be submitted directly to NANB.

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Characteristics	Very Good	Average	Fair	Poor
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1) peers				
2) clients				
3) co-workers				
4) other professionals				
C. Nursing Potential				
1) ability to organize work				
2) ability to apply knowledge				
3) ability to meet the standards of care				
4) leadership				

On the basis of past performance, would you re-employ this nurse? ÿ Yes ÿ No

If no, please elaborate: _____

_____

Is this reference based on personal knowledge? ÿ Yes ÿ No **or personnel file?** ÿ Yes ÿ No

Printed name: _____ **Signature:** _____

Title: _____ **Agency:** _____

Address: _____

Date: _____ **Telephone number:** (_____)_____

This reference must be submitted directly to NANB.

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CONFIRMATION OF HOURS

SECTION A *(To be completed by applicant and forwarded to Nursing Employers over the past five years.)*

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Date of birth _____/_____/_____
Day Month Year

I was employed at your agency as a Registered Nurse from _____/_____ **to** _____/_____.
Month / Year Month / Year

I hereby authorize you to release the information requested on this form to NANB.

_____ _____
Date Signature

SECTION B *(To be completed by employer and returned directly to NANB.)*

I do hereby certify that _____ **practiced as a Registered Nurse in this institution.**
Name of Nurse

The following is an accurate account of actual worked hours per year for each of the past five years.

Jan 1, _____ to Dec31, _____ = _____ hours
year year

Jan 1, _____ to Dec31, _____ = _____ hours
year year

Jan 1, _____ to Dec31, _____ = _____ hours
year year

Jan 1, _____ to Dec31, _____ = _____ hours
year year

Jan 1, _____ to Dec31, _____ = _____ hours
year year

EMPLOYER INFORMATION

_____
Printed name Signature Date

_____
Position Title Agency/institution name

_____
Address

_____
Telephone number E-mail

This form must be submitted directly to NANB.

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NURSING EDUCATION INFORMATION

Section A- *Applicant Information. (To be completed and forwarded to your initial School of Nursing.)*

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Date of birth _____/_____/_____ **Date of graduation** _____/_____/_____
Day Month Year Day Month Year

School of Nursing: _____
Full name of school of nursing

Location: _____
City State / Province Country

_____ _____
Date Signature

Section B *Nursing Education. (To be completed by the school official only.)*
Please return directly to NANB with an official transcript and a description of course content.

Name of Applicant: _____ **Language of instruction**: _____

Date of admission: _____/_____/_____ **Completion date** _____/_____/_____
Day Month Year Day Month Year

	Clinical Hours	Theoretical Hours	Total
Surgical Nursing			
Medical Nursing			
Obstetrical Nursing			
Pediatrics Nursing			
Psychiatric/Mental Health Nursing			
Other (specify)			
Total Number of Hours			

I certify that the above is an accurate copy of the records of the applicant whose name appears on this form and that the applicant satisfactorily completed the Nursing program.

_____ _____
Position Title Printed name

_____ _____
Date Signature

Official Seal/Stamp

This form must be submitted directly to NANB.