BERMUDA NURSING COUNCIL

MINISTRY OF HEALTH, SENIORS, and ENVIRONMENT
P.O. Box HM 674, Hamilton HM CX Bermuda
3rd Floor Sterling House, #16 Wesley St. Hamilton HM 11 Bermuda
Telephone 441 292-0774 Fax 441 232-1823
E-mail: bermudanursingcouncil@gov.bm

REGISTRATION OF NURSES APPLICATION FORM

Please print all information. Complete each section and submit the application together with the required supporting documents.

SECTION 1. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Name: ____
Last First Middle Maiden

Date of Birth: Month______________ Day____________ Year____________

Nationality____________________ Country of Birth____________________

Sex: Male □ Female □

Languages Spoken ____________________ ____________________

SECTION 2. CONTACT ADDRESS

Street____

City________________ Country________________ Code____________

E-Mail____________________ Telephone____________________

SECTION 3. EDUCATION

Name of Nursing School ______________________________________

City____________________ Country____________________

Graduation Date____________________ Degree Obtained____________________

Other Nursing Qualifications ______________________________________

SECTION 4. REGISTRATION CATEGORY

Registered Nurse (General) □ Psychiatric Nurse □ Nurse Specialist ☐

Advanced Practice Nurse □ Specify ______________________

Prospective Employer in Bermuda______________________

SECTION 5. SCREENING QUESTIONS

Answer the following questions by placing a tick (✓) in the appropriate box. If you answer "yes" to any of these questions you are required to provide complete details **on a separate sheet of paper** and attach to this form.

		Yes	No
1.	Do you hold licensure or are you registered (active, inactive, or expired) to practice in any other jurisdiction?		
2.	Have you ever withdrawn an application for registration, had an application denied or refused, or agreed not to reapply for registration in another country?		
3.	Has any disciplinary action been taken against you by any regulatory authority?		
4.	Have you been convicted, found guilty, or pleaded guilty or nolo contendere to any offence?		
5.	Do you have a physical or medical condition that currently impairs your ability to practice nursing?		
6.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs?		

SECTION 6. SUPPORTING DOCUMENTS

The following documents must accompany your application: Please note that all copied documents must be notarized by a licensed Notary Public. (A Justice of the Peace stamp or seal does not suffice) Note also that the Verification of Registration form must be sent to us by your Nursing Council.

1) Copy of your initial license or certificate of registration
2) Copy of a current nursing license which includes an expiry date
3) Copy of Nursing Diploma/Degree and other qualifications
4) Copy of document signifying name change if any
5) CV/Resume
6) Copy of a MELAB, IELTS or TOEFL examination result when English is not the official language of your native country.
7) Character reference
8) Copy of police report from the jurisdiction where you have resided during the last three years
9) Registration fee of U.S. $ 80.00 per registration category in the form of a Cashier's cheque, a Bank draft or an International Money Order made payable to the Accountant General. Do not send cash or personal cheque. Debit/Credit cards are not accepted. When made in person, cash payment in Bermuda or U.S. dollars is acceptable.

SECTION 7. SIGNED STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements may result in the revocation of my registration.

Signature:________________________ **Date** ______________

Witness: ____________________________ Seal

Must be a Notary Public

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VERIFICATION OF NURSE REGISTRATION FORM

PART A: Applicant to Complete

Please complete Part A of this form and forward a copy to each regulatory body in which you have been registered as well as the regulatory body in which you are currently registered.

Please Print:

Last Name____

Forenames____

Former Name____________________ Date of birth: ____________________

Registration Date: __________________ Registration #:____________________

I am applying for nurse registration in Bermuda and a record of my nurse registration is required.

Signature________________________ Date________________________

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PART B: Regulatory Body to Complete

Please complete Part B of this form and mail it to the Bermuda Nursing Council at the address above.

Please Print

Name of Regulatory Body: ____

Name of Registrant: Last Name____

Forenames____

Former Name________________________ Date of Birth____________________

Registration #______________ Date of Issue: ______________ Status:____________

Expiration Date: ________________________

Registration Granted (title):____

Registered by (Please circle one) Examination Endorsement

a) Has the above named person's registration ever been denied, suspended, revoked, or under investigation? Yes□ No□
b) Have any special conditions been placed on his/her practice? Yes□ No□
c) Are there any factors known to you that would impact on this registrant's fitness to practice? Yes□ No□

If Yes to any of the above, please attach an explanatory note.

Name of person completing this form________________________________

Title____________________ Signature__________________ Date__________

Authority Seal