



Ministry of Health

BERMUDA NURSING AND MIDWIFERY COUNCIL

P.O. Box: HM1195, Hamilton HM EX, Bermuda | Website: www.bnc.bm

E-mail: bermudanursingcouncil@gov.bm | Phone: (441) 292-0774 / 278-4910, Fax: (441) 232-1823



NURSE APPLICATION FOR RENEWAL OF REGISTRATION

Please read instructions for Retention on Active Register before completing this application. Kindly complete all sections of the form and attach all requisite documentation.

Last Name _____ First Name _____ Middle Name _____ Maiden Name _____

Date of Birth _____ Gender Male Female Email _____

Address _____

Tel. (W) _____ Cell _____ (H) _____

Bermudian Spouse of Bermudian PRC Non-Bermudian

License Category: APN License # RN (General) License # RMN (Psychiatry) License #
 Nurse Specialist License #

Have you been engaged in the nursing profession for a minimum of 100 hours during the past year? Yes No

If you are not currently employed in Bermuda you must provide proof of employment. (Notarized letter from supervisor or employer)

If you answered **No**, do you wish to appeal for licensure?

Employer _____

Full Time Part time Casual

If you answer yes questions 1-4 below, and you have not previously reported the matter to BNMC please provide details on a separate sheet and attach to this form.

1. Have you been disciplined, convicted, found guilty or nolo contendere (no contest) to any offence within the past two years? Yes No
2. Do you have pending charges or complaints against your nursing practice/misconduct? Yes No
3. Have you voluntarily or involuntarily resigned from employment during an investigation against your practice of nursing or misconduct? Yes No
4. Are you addicted to the misuse of alcohol and or to the habitual use of narcotics or other habit forming drugs?
 Yes No If yes are you currently in rehabilitation program? Yes No
5. Have you met CE (continuing education, 24 hours) requirements? Yes Please provide evidence (copy of certificates). -Attach to form, and complete BNMC Continuing Record of Attendance form provided.

7. Evidence of current CPR /BLS–Attach to form

7. Highest level of Nursing or Midwifery Education; please check the appropriate response below

8. PhD MSN/MSc APN BSN/BSc ADN

Diploma/ Certificate or Other, Specify _____

If you are employed in Bermuda; please check the appropriate response below.

My primary role is Clinical Administrative Education Other

Signed Statement:

I verify that the information contained in this application is true and correct to the best of my knowledge and belief. I understand that any false statement or omission may result in the revocation of my license.

Applicant Signature _____ **Date** _____

