

NURSING COUNCIL

COMMONWEALTH OF THE BAHAMAS

Virginia and Augusta Streets

Nassau, Bahamas

Post Office Box: N-8506

Telephone Number: 1-242-604-6015 / 1-242-604-6017

Email: info@nursingcouncilbahamas.com

**APPLICATION FOR REGISTRATION AS A NURSE**

I have enclosed an application for registration as a nurse with **certified** copies of the following requirements:

**Please tick appropriate boxes to ensure all information is completed**

|  |  |
| --- | --- |
|  | **Birth Certificate** |
|  | **First 4 pages of current passport** |
|  | **Marriage Certificate (if applicable)** |
|  | **Divorce Certificate (if applicable)** |
|  | **Police Character Reference/s issued within the past 6 months from the jurisdiction/s where you have resided during the last 3 years**  |
|  | **Medical Report** |
|  | **One passport-sized photograph (original; 2” X 2”)** |
|  | **Verification of Registration**  |
|  | **Official Transcript (Please detach form and forward to each Nursing School attended)** |
|  | **Nursing Degree/s obtained:**  |  | **Dip.** |  | **ASN** |  | **BSN** |  | **MSN** |  | **PhD** |
|  | **Current Registration Certificate**  |
|  | **Nursing License**  |  | **Active** |  | **Inactive** |
|  | **Three References:**  |  | **Professional** |  | **Professional** |  | **Character** |
|  | **Application Fee ($170.00 USD)**  |
|  | **Summary of Post-registration Clinical Experience** |

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY**

1. No application will be reviewed/processed until **ALL** of the above-listed requirements are received. The application **must** accompany an **active** registration/license **certified** as a true copy by the Board of Nursing with which you are registered.

Please Note: **All documents must be certified by a licensed attorney or notary public.**

1. The evaluation process can take up to three (3) months after receipt of all the relevant documents. Any withdrawals or correspondence should be addressed in writing to the Registrar of The Nursing Council.

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1. Legal action **will be** taken against any person who gains employment as a nurse and is **not** registered to practice in The Bahamas.
2. Application fee of one hundred and seventy dollars USD ($170.00) must be paid when the application is submitted.

**PLEASE NOTE THAT THE APPLICATION FEE IS NON-REFUNDABLE.**

1. All references **must** be submitted in sealed envelopes, one of which must be from a nursing supervisor. The other professional reference may be obtained from either a nursing leader or a physician. The character reference may be obtained from a religious or community leader.
2. Verification of your registration must be forwarded directly from your Nursing Council/Regulatory Body to the Registrar of The Nursing Council of The Bahamas.
3. Incomplete applications for registration will be discarded by the Council after six months from the date of initial request. Should you wish to pursue registration beyond six months after the date of the initial request a new application for registration must be submitted.

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**Application by a person trained outside The Commonwealth of The Bahamas**

**For admission to the Register of Nurses**

To: The Registrar, Nursing Council of The Commonwealth of The Bahamas

 **(Please print)**

1. Full Name ………………………………………………………………………………………

 Surname First Name Middle Name

1. State whether single, married, widowed or divorced …………………………………………..
2. If married, give maiden name ………………………………………………………………….
3. Date of Birth …………………………………………………………………………………...
4. Place of Birth …………………………………………………………………………………..
5. Nationality ……………………………………………… Phone # …………………………...
6. Home Address ………………………………………………………………………………….

………………………………………………………………………………………………….

1. Permanent Postal Address ……………………………………………………………………...

…………………………………………………………………………………………………..

1. Email Address ………………………………………………………………………………….
2. Name of Training School.………………………………………………………………………

…………………………………………………………………………………………………..

1. Address of Training School ……………………………………………………………………

…………………………………………………………………………………………………..

1. Period of Training (***exact dates***): From (a) …………………… to (b) …………………….…
2. Have you applied for employment in The Bahamas? ……………………………

If Yes please give the names of all agencies you have applied to:

1. ……………………………………………
2. ……………………………………………
3. ……………………………………………

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I hereby request the Council to enter my name upon the Register of Nurses maintained by the Council.

I forward herewith my application and processing fee and I promise in the event of my being registered, to be bound by and to conform in all respects to the Regulations for the time being in force.

Signature of Applicant:…………………………………………………………………………..…

Date: ………………………………………………………………………………………………..

N.B.: The copy of your certificate of registration must be certified to be a true copy by an attorney or a notary public.

Attach Photograph (do not paste)

FORM TO BE RETURNED TO THE REGISTRAR, NURSING COUNCIL, COMMONWEALTH OF THE BAHAMAS.

For Office Use Only

|  |  |
| --- | --- |
| Registration Number |  |
| Registration Date |  |

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Summary of Post-Registration Clinical Experience completed

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Dates | Post held and experience gained | Institution(full address) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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**CONFIDENTIAL MEDICAL REPORT**

***Part 1 (To be completed by Applicant)***

1. Name …………………………………………………………...……. 2. Age: ……………

3. Relevant Family History ………………………………………………………………………...

………………………………………………………………………………………..…………

4. Personal History (a) Surgery, serious illnesses, etc. ……………………………………………

………………………………………………………………………………………………………

………………………………………………………………………………………………………

(b) Disabilities, allergies, etc. ……………………………………………………………………...

………………………………………………………………………………………………………

***Part II (To be completed by Physician)***

1. Physical and general health ……………………………………………………………………..

………………………………………………………………………………………………………

2. Heart …………………………………………………………………………………………….

3. Lungs ……………………………………………………………………………………………

4. Abdominal organs ………………………………………………………………………………

5. Nervous System (and emotional stability) ……………………………………………………...

6. Vision ………………………………………………

 7. Hearing ……………………………..

PLEASE COMPLETE **ALL** AREAS

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***Part III (to be completed by Physician)***

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Does the candidate suffer from any physical defect or physical disability?

………………………………………………………………………………………………………

Name of physician …………………………………………………………………………………

Signature …………………………………………………………………………………………...

Date ………………………………………………………………………………………………...

Address ……………………………………………………………………………………………

Please affix official seal or stamp for Physician’s office

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**TRANSCRIPT OF NURSING EDUCATION IN A FOREIGN COUNTRY**

**SECTION A**

**To Applicant: Complete section A (pages 8 & 9) of this form and send it to your Nursing School. TYPE OR PRINT IN INK. This form may be reproduced if more than one form is needed to send to other Training Schools.**

Name of Applicant ………………………………………………………………………………...

 Last Name First Name Middle Name

Mailing Address …………………………………………………………………..……………….

 Street City

…………………………………………………………………………….…………

State/Province Country

……………………………………………………………………………………….

Postal Code Telephone

Date of Birth ………/………../……..………

 Date Month Year

**Type of Nursing Qualification (please circle as appropriate)**

Certificate / Diploma / Associates Degree / Bachelors Degree / Masters Degree / PhD

Post Basic Qualification (Please specify)………………………………………………………....

Other (Please specify) ...……………………………………………………………………….….

Admission to Nursing Programme ………../…………..

 Month Year

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Month and year of graduation ……………………………/ ……………………………………….

Length of Training …………………………………………………………………………………

Name of Training School of Nursing ………………………………………………………………

Mailing Address of Training School ……………………………………………………………….

 Street City

………………………………………………………………………………………………………

State/Province Country

………………………………………………………………………………………………………

Postal/Zip Code Telephone Number E-mail Address

**I authorize release of information requested to the Nursing Council, The Commonwealth of The Bahamas.**

**Signature…………………………………………………. Date…………………………………**

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**SECTION B**

**To the Director of the Training School:**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This form is required as part of the above-named applicant’s record and should be submitted with an OFFICIAL SCHOOL TRANSCRIPT. Please fill in all parts of the form and report ALL THEORY AND CLINICAL PRACTICE as they apply to the program of study. Return the completed form directly to The Registrar, The Nursing Council, Commonwealth of The Bahamas.**

**1. Did the program of study include courses in: Tick ( ✓ ) as appropriate:-**

**COURSES N/A YES NO**

Anatomy \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Physiology \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Microbiology \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Chemistry \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Nutrition \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Pharmacology \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Psychology \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sociology \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

2. What was the language of instruction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3a. Please state the total number of theoretical/instruction hours for the subject areas listed below. If the curriculum is integrated, estimate the hours of instruction in the areas listed.

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|  |  |
| --- | --- |
| **SUBJECT INCLUDES AFFILLIATED COURSES** | **HOURS OF THEORY / INSTRUCTION** |
|  | **Hours per week completed** | **Total number of weeks completed** | **Total Hours** |
| Medical Nursing |  |  |  |
| Surgical Nursing |  |  |  |
| Paediatric Nursing |  |  |  |
| Obstetric Nursing |  |  |  |
| Operating Theatre |  |  |  |
| Psychiatric Nursing(for R.N.) |  |  |  |
| Community Nursing |  |  |  |
| Gynaecological Nursing |  |  |  |
| Emergency Nursing |  |  |  |
| Intensive Care Nursing |  |  |  |
| At least one other type of Nursing Subject |  |  |  |

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**3b. Please list the total number of practice hours for the subject areas listed below:**

**Include laboratory and clinical hours in these hours****. If the curriculum is integrated, estimate the clinical hours and practice hours in the areas listed.**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **SUBJECT INCLUDES AFFILLIATED PRACTICE** | **HOURS OF LABORATORY AND** **CLINICAL PRACTICE** |
|  | **Laboratory Hours per week completed** | **Total number of weeks completed** | **Total****Lab Hours****Completed** |  | **Clinical Hours per week completed** | **Total number of weeks completed** | **Total****Clinical Hours****Completed** |
| **Medical Nursing** |  |  |  |  |  |  |  |
| **Surgical Nursing** |  |  |  |  |  |  |  |
| **Paediatric Nursing** |  |  |  |  |  |  |  |
| **Obstetric Nursing** |  |  |  |  |  |  |  |
| **Operating Theatre** |  |  |  |  |  |  |  |
| **Psychiatric Nursing** |  |  |  |  |  |  |  |
| **Community Nursing** |  |  |  |  |  |  |  |
| **Gynaecological Nursing** |  |  |  |  |  |  |  |
| **Emergency Nursing** |  |  |  |  |  |  |  |
| **Intensive Care Nursing** |  |  |  |  |  |  |  |
| **Any other type of Nursing Experience (specify)** |  |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |  |

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Please note: If the applicant did not graduate from the programme, give the date and reason/s for withdrawal below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the information submitted is an accurate record of the applicant.

Name of Director of Training School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Director of Training School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SCHOOL

SEAL OR

STAMP

Date …………………………………………………………………………………