THE DEPARTMENT OF HEALTH REGULATORY SERVICES

Health Practice Commission

Nursing and Midwifery Council Application Checklist

Applicant's Name: _____ **D.O.B.:** _____

Profession: _____ **Specialty:** _____

Time: **Reg. Type: *PL*, IL, ProvL, ProvI Student Nurse**

Date:	**Attending Officer:**		**Comments**
1	☐ Application: CI$500.00 ☐ Registration CI$_____ ☐ Practising CI$_____ ☐ Total Months _____		
2	Passport-size photograph	☐ Dated:	
3	Application Form – Form A1	☐	
4	Letter of Verification: _____ Start Date: _____	☐ Dated:	
5	Director Practitioner Form CA - copy	☐	
6	Character reference [+4 years] Name:	☐ Dated:	
7	Police certificate Country:	☐ Dated: ☐ Date Exp.:	
8	Health Insurance Letter/Card	☐ Dated:	
9	Copy of passport	☐ Exp. date:	
10	Other:		