



# Nurses Association of New Brunswick

165 Regent St., Fredericton, New Brunswick, Canada E3B 7B4  
Tel.: (506) 458-8731 Fax: (506) 459-2838 Toll Free in New Brunswick: 1-800-442-4417  
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## REGISTRATION RENEWAL 2010

COMPLETE BOTH SIDES OF THIS FORM AND MAKE CORRECTIONS IF NECESSARY TO THE INFORMATION GIVEN

### PERSONAL DATA

**1. GENERAL INFORMATION :** Name & Mailing Address:

Maiden Name: \_\_\_\_\_ Other Former Names: \_\_\_\_\_

Tel. (Home): \_\_\_\_\_ Tel. (Work): \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**2. N.B. REGISTRATION NO :** \_\_\_\_\_ **3. LANGUAGE PROFICIENCY :**

<b>4. GENDER :</b> 1. <input type="checkbox"/> M 2. <input type="checkbox"/> F	<b>5. DATE OF BIRTH :</b> Day / Month / Year ____ / ____ / ____	<b>6. I DESIRE MATERIAL IN :</b> 1. <input type="checkbox"/> English 2. <input type="checkbox"/> French	Please check one. 1. <input type="checkbox"/> Unilingual English 2. <input type="checkbox"/> Unilingual French 3. <input type="checkbox"/> Fluently Bilingual (first language English) 4. <input type="checkbox"/> Fluently Bilingual (first language French) 5. <input type="checkbox"/> Functionally Bilingual (first language English) 6. <input type="checkbox"/> Functionally Bilingual (first language French)
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**7. STATUS REQUESTED :** Fees, including HST, must be received on or before December 1, 2009. Please allow 3-4 weeks for delivery of certificate. No refunds after Dec.31. All amounts in Canadian Dollars only.

1.  REGISTRATION fee \$393.00 (after Dec. 31 \$449.50). Fees reduced after July 1.  
2.  NON PRACTISING MEMBERSHIP fee \$45.20 (after Dec. 31 \$56.50) – Add \$60.78 if you wish CNA membership.  
3.  REGISTERED NURSE RETIRED membership – no fee.  
4.  RESIGNATION

**8. HOURS WORKED IN NURSING :** I certify that the following is an accurate account of my actual hours worked and does not include vacation or any leave of absence. Note: If you worked outside of New Brunswick in 2009 and are requesting full registration, please have that jurisdiction send a verification of registration to NANB and have your employer send a confirmation of hours worked directly to NANB.

Jan. 1 to Dec. 31, 2009: \_\_\_\_\_ hours (Primary employer)  
Jan. 1 to Dec. 31, 2009: \_\_\_\_\_ hours (Secondary employer)  
Previous nursing hours reported: 2008 \_\_\_\_\_ 2007 \_\_\_\_\_ 2006 \_\_\_\_\_ 2005 \_\_\_\_\_

**9. CONTINUING COMPETENCE REQUIREMENTS :** I have assessed my practice and developed, implemented and evaluated a learning plan for 2009  Yes  No

**10. SINCE YOU LAST APPLIED FOR REGISTRATION, HAVE YOU BEEN CHARGED WITH OR CONVICTED OF A CRIMINAL OFFENCE?** No  Yes\*  \*IMPORTANT: You must contact the Registrar at 1-800-442-4417 or 458-8731

<b>11. BASIC NURSING EDUCATION :</b>	<b>12. POST-RN EDUCATION IN NURSING :</b>	<b>13. EDUCATION OTHER THAN NURSING :</b>
PROGRAM YEAR	PROGRAM YEAR	PROGRAM YEAR
1. <input type="checkbox"/> Diploma leading to RN _____	1. <input type="checkbox"/> Baccalaureate _____	1. <input type="checkbox"/> Baccalaureate _____
2. <input type="checkbox"/> Baccalaureate leading to RN _____	2. <input type="checkbox"/> Masters _____	2. <input type="checkbox"/> Masters _____
3. <input type="checkbox"/> Masters degree leading to RN _____	3. <input type="checkbox"/> Doctorate _____	3. <input type="checkbox"/> Doctorate _____
Specify province or country of graduation: _____	4. <input type="checkbox"/> Certificate/Diploma * (300 Hrs or more) (specify) _____	4. <input type="checkbox"/> Certificate/Diploma (300 Hrs or more) (specify) _____
	5. <input type="checkbox"/> CNA Certification (specify) _____	5. <input type="checkbox"/> None of the above
	6. <input type="checkbox"/> None of the above	

\* These courses must be approved by an authority such as an education institution or professional association

DO NOT DETACH

DO NOT DETACH

**14. PAYMENT :**  Cash  Cheque  Money Order  Payroll Deduction  Credit Card \*

Please charge my: \_\_\_\_\_ Credit Card Number \_\_\_\_\_ Expiry \_\_\_\_\_

VISA  MasterCard

Amount \$ \_\_\_\_\_ Name On Card \_\_\_\_\_ Cardholder's Signature \_\_\_\_\_

Continue on reverse

**CURRENT NURSING EMPLOYMENT DATA**

**15. CURRENT NURSING EMPLOYMENT:** Do you have more than one job?  Yes  No

**PRIMARY PLACE OF WORK**

Facility name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_  
 Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**SECONDARY PLACE OF WORK**

Facility name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_  
 Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**16. EMPLOYMENT STATUS:** Fill in for primary and secondary employment using appropriate number:

Primary Employment  Secondary Employment

- |                                |                                |                        |                             |                                      |
|--------------------------------|--------------------------------|------------------------|-----------------------------|--------------------------------------|
| <b>FULL TIME</b>               | <b>PART-TIME</b>               | <b>TEMPORARY</b>       | <b>CASUAL</b>               | <b>CURRENTLY ON LEAVE OF ABSENCE</b> |
| 1. Full time by choice         | 3. Part time by choice         | 5. Temporary part-time | 7. Casual by choice         | 10. Maternity Leave                  |
| 2. Full time seeking part-time | 4. Part time seeking full-time | 6. Temporary full-time | 8. Casual seeking part-time | 11. Sick Leave                       |
|                                |                                |                        | 9. Casual seeking full-time | 12. Long-term disability             |
|                                |                                |                        |                             | 13. Other: _____                     |

Fill in for primary and secondary employment using appropriate number:

**17. PLACE OF WORK :**

- |   |                          |
|---|--------------------------|
| Primary                                       | Secondary                |
| <input type="checkbox"/>                      | <input type="checkbox"/> |
| 1. General Hospital                           |                          |
| 2. Rehab Centre                               |                          |
| 3. Psychiatric Hospital                       |                          |
| 4. Extra-Mural Program                        |                          |
| 5. Residential Facilities                     |                          |
| 6. Nursing Home / Veterans Unit               |                          |
| 7. Public Health Service                      |                          |
| 8. Victorian Order of Nurses                  |                          |
| 9. Health Services Centre                     |                          |
| 10. Mental Health Clinic                      |                          |
| 11. Physician's Office / Family Practice Unit |                          |
| 12. Occupational Health / Business / Industry |                          |
| 13. Educational Institution                   |                          |
| 14. Self-employed                             |                          |
| 15. Association                               |                          |
| 16. Government                                |                          |
| 17. Addiction Centre                          |                          |
| 18. Fed / Prov Correctional Institute         |                          |
| 19. Armed Forces                              |                          |
| 20. Home Care Agency / Private Duty           |                          |
| 21. Community Health Centre                   |                          |
| 22. Hospital Satellite Facility               |                          |
| 23. Other (specify)                           |                          |

**18. POSITION :**

- |  |                          |
|--|--------------------------|
| Primary  | Secondary                |
| <input type="checkbox"/>                           | <input type="checkbox"/> |
| 1. Staff Nurse / Community health nurse            |                          |
| 2. Head Nurse / Unit Manager                       |                          |
| 3. Instructor / Professor / Educator               |                          |
| 4. Supervisor / Coordinator                        |                          |
| 5. Clinical Nurse Specialist                       |                          |
| 6. Director / Assistant Director                   |                          |
| 7. Chief Nursing Officer / Chief Executive Officer |                          |
| 8. Consultant                                      |                          |
| 9. Researcher                                      |                          |
| 10. Nurse Practitioner (N.P.)                      |                          |
| 11. Other (specify)                                |                          |

**19. PRIMARY AREA OF PRESENT PRACTICE :**

- |                                    |                               |
|------------------------------------|-------------------------------|
| Primary                            | Secondary                     |
| <input type="checkbox"/>           | <input type="checkbox"/>      |
| <b>DIRECT PATIENT CARE:</b>        | <b>ADMINISTRATION:</b>        |
| 1. Medical / Surgical              | 21. Nursing Education         |
| 2. Maternal / Newborn              | 22. Nursing Service           |
| 3. Mental Health / Psychiatric     | 23. Other                     |
| 4. Pediatrics                      | <b>EDUCATION:</b>             |
| 5. O.R.                            | 24. Student Programs          |
| 6. Ambulatory Care / Day Surgery   | 25. Employee Programs         |
| 7. Geriatrics / Extended Care      | 26. Patient / Client Programs |
| 8. R.R.                            | <b>RESEARCH:</b>              |
| 9. Rehabilitative Care             | 27. Nursing Research          |
| 10. Chemical Dependency            | 28. Other Research            |
| 11. Several Clinical Areas / Float | <b>OTHER:</b>                 |
| 12. Community Health               | 29. Discharge planning        |
| 13. Occupational Health            | 30. Infection Control         |
| 14. Critical / Intensive Care      | 31. Informatics               |
| 15. Oncology                       | 32. Other (specify)           |
| 16. Telepractice                   |                               |
| 17. Emergency                      |                               |
| 18. Dialysis / Nephrology          |                               |
| 19. Palliative Care                |                               |
| 20. Other Patient Care             |                               |

**NOT EMPLOYED IN NURSING**

**20. ARE YOU SEEKING EMPLOYMENT IN NURSING?**  Yes  No Please indicate your present situation.

- |  |  |  |
|--|--|--|
| 1. <input type="checkbox"/> Not employed                   | 3. <input type="checkbox"/> Seeking refresher course | 5. <input type="checkbox"/> Seeking employment in other than nursing |
| 2. <input type="checkbox"/> Employed in other than nursing | 4. <input type="checkbox"/> Retired                  |  |

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.**

I understand NANB collects, uses and discloses 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 and also to provide or offer services to its members directly or through the Canadian Nurses Association, Canadian Nurses Protective Society, Meloche Monnex and others when NANB determines such services may be of interest to members. I understand I may contact NANB at any time to determine the use or disclosure of information I provide to NANB.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_