Nurses Association **Association des infirmières et infirmiers**
OF NEW BRUNSWICK DU NOUVEAU-BRUNSWICK
165, rue Regent Street, Fredericton N.-B., Canada, E3B 7B4
Tel. : (506) 458-8731 Fax. : (506) 459-2838 Toll Free: 1 800 442-4417
Email: nanbregistration@nanb.nb.ca

For office use
Date of receipt stamp

APPLICATION FOR REINSTATEMENT OF REGISTRATION 2019

A. PERSONAL INFORMATION

If your name is different than the one under which you were last registered in New Brunswick please forward a copy of your marriage certificate or a declaration of change of name.

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Current address: _____
Apt # Street Name

_____
City Province / State Postal Code / Zip Code Country

Telephone number: (_____) _____ (_____) _____
Home Cell phone

Email address: _____

Gender: ☐ Female ☐ Male **I desire material in:** ☐ English ☐ French

Date of birth _____/_____/_____ **NANB Registration #:** _____
Day Month Year

B. STATUS REQUESTED (indicate the status you require and refer to page 3 for fee schedule)

☐ Registration-Registered Nurse ☐ Registration-Nurse Practitioner ☐ Non Practising Status

I have assessed my practice and developed, implemented and evaluated a learning plan for 2018.

☐ Yes ☐ No Specify: _____

Have you ever been denied registration in another province, territory, state or country?

☐ Yes ☐ No Specify: _____

Is your registration currently suspended, revoked, subjected to conditions or restrictions, or under investigation in another jurisdiction?

☐ Yes ☐ No Specify: _____

Since you last applied for registration, have you been charged with or convicted of a criminal offence?

☐ Yes ☐ No Specify: _____

C. APPLICANTS RESIDING IN NB

Are you currently employed? ☐ Yes ☐ No **Are you anticipating new employment** ☐ Yes ☐ No

Name and location of current employer: _____

Name and location of anticipated employer: _____

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Are you returning to work after leave of absence? ☐ Yes ☐ No If Yes From:_____To:_____
dd/mm/yy dd/mm/yy

Specify type of leave: Maternity Leave ☐
Sick Leave ☐
Long Term Disability ☐
Other ☐ Specify _____

D. APPLICANTS RESIDING OUTSIDE OF NEW BRUNSWICK

Did you work as an RN outside of NB since you were last registered with NANB? ☐ Yes ☐ No

A confirmation of hours of work form must be completed by all employers in the last 5 years, and sent directly to NANB. Also a verification of registration from the regulatory body where you are currently registered is required.

Name and Address of Employer	Your Position	Period of Employment
		From:_____To:_____
		From:_____To:_____
		From:_____To:_____

E.VERIFICATION OF CURRENT REGISTRATION

A verification of registration from the regulatory body where you are currently registered must be completed by the regulatory body where you are currently registered and sent directly to NANB.

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 or others ("third parties") when NANB determines such services may be of interest to members. I consent to receiving electronic communications from NANB and third parties respecting such services and understand I may withdraw this consent at any time. I understand I may contact NANB at any time to determine the use or disclosure of information I provide to NANB.

_____ _____
Date Signature

F. PAYMENT(See next page for correct registration fee schedule)

I am paying by ☐ Certified cheque ☐ Money order ☐ Visa ☐ MasterCard ☐ Cash $_____

Credit card users, please complete the following information:

Card number:___/___/___/___/-___/___/___/___/-___/___/___/___/-___/___/___/___ Expiry date ___/___/-___/___

_____ _____
Name of cardholder Authorizing signature

Revised 2014-09-19

Complete, sign and return this form to NANB along with the registration fee.

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F. 2019 REGISTRATION FEES (in Canadian funds only)

Forward the registration fee on the basis of the date on which you anticipate practising nursing in New Brunswick. Registration certificates remain valid until the 30 of November of each year.

REGISTRATION FEES

December 1, 2018 - November 30, 2019	$556.14
If lapsed	$613.64
June 1, 2019 - November 30, 2019	$333.68
If lapsed	$391.18
September 1, 2019 - November 30, 2019	$166.84
If lapsed	$224.34

NON PRACTISING FEES

Non practising membership	$46.00
If lapsed	$57.50
Non practising membership with membership in the Canadian Nurses Association	$115.69
If lapsed	$127.19

Non practising membership entitles the member to receive all Association publications, participate in Chapter activities and enrol in a refresher course. Non practising membership is for nurses who are not engaged in the active practice of nursing in New Brunswick.

TRANSFER FROM NON PRACTISING TO PRACTISING FEES

These fees include a credit for non practising fees previously paid

December 1, 2018 - November 30, 2019	$510.14
June 1, 2019 - November 30, 2019	$287.68
September 1, 2019 - November 30, 2019	$120.84

(Above fees include 15 % HST)

Please contact the **Registration Department** for further information or clarification at (506) 458-8731 or 1-800-442-4417 (NB only).

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VERIFICATION OF CURRENT REGISTRATION

SECTION A (*To be completed by applicant and forwarded to the Regulatory Body which granted your current nursing registration.)*

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Current address: _____
Apartment # Street Number and Name

_____
City Province / State Postal Code / Zip Country

Date of birth _____/_____/_____ **My registration number in your Jurisdiction** : _____
Day Month Year

Graduated from: _____ **Date of graduation:**_____/_____/_____
School of Nursing Day Month Year

_____ _____
Date Signature

SECTION B (*To be completed by the Regulatory Body and forwarded directly to NANB.)*

Acting on behalf of _____**, I do hereby certify that**
Regulatory Body
_____**a graduate of** _____
Name of applicant School of nursing

located in _____**was issued a certificate of registration as a**
City Province/State Country

Registered Nurse on _____/_____/_____**, bearing number** _____
Day Month Year

The certificate was obtained by: ☐ Examination
☐ Endorsement

EXAMINATION INFORMATION	☐ CRNE
Registration Examination:	☐ NCLEX
Passing Score: _____	☐ Other (specify)
Number of times written:_____	_____

The applicant's current registration status with this authority _____ **Valid until** _____

The applicant's registration / membership status for the past five years:	**Year**	**Status**
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Is this registration presently suspended, revoked, subjected to conditions or restrictions, or under investigation? ☐ Yes ☐ No

_____ _____
Date Printed name and Signature

Official Seal/Stamp

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CONFIRMATION OF HOURS

SECTION A *(To be completed by applicant and forwarded to Nursing Employers over the past five years.)*

Name: _____
Last name First name Middle name

Maiden name: _____ **Former name(s):** _____

Date of birth _____/_____/_____ **Registration #:** _____
Day Month Year

I was employed at your agency as a Registered Nurse from _____/_____ **to** _____/_____.
Month / Year Month / Year

I hereby authorize you to release the information requested on this form to NANB.

_____ _____
Date Signature

SECTION B *(To be completed by employer and returned directly to NANB.)*

I do hereby certify that _____ **practised as a Registered Nurse in this institution.**
Name of Nurse

The following is an accurate account of actual worked hours per year for each of the past five years.

Jan 1, _____ to Dec 31, _____ = _____ hours
year year

Jan 1, _____ to Dec 31, _____ = _____ hours
year year

Jan 1, _____ to Dec 31, _____ = _____ hours
year year

Jan 1, _____ to Dec 31, _____ = _____ hours
year year

Jan 1, _____ to Dec 31, _____ = _____ hours
year year

EMPLOYER INFORMATION

_____
Printed name Signature Date

_____
Position Title Agency/institution name

_____
Address City Province / State Country

_____
Telephone number E-mail

This form must be submitted directly to NANB.