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|-----------------------|
| <b>For office use</b> |
| Date of receipt stamp |
|                       |

## APPLICATION FOR REINSTATEMENT OF REGISTRATION 2022

### 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  Non-Binary

**I desire material in:**  English  French

**Date of birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

**NANB Registration #:** \_\_\_\_\_

### 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 2021.**

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:** \_\_\_\_\_



**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

REG

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 WITH WORK 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 is required to be completed and sent directly to NANB by all regulatory bodies where you have been registered since your last active registration with 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. 2022 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.

| <b><u>REGISTRATION FEES</u></b>  |          |
|--|----------|
| December 1, 2021 - November 30, 2022   | \$582.65 |
| If lapsed  | \$640.15 |
| June 1, 2022 - November 30, 2022   | \$373.55 |
| If lapsed  | \$431.05 |
| September 1, 2022 - November 30, 2022  | \$244.18 |
| If lapsed  | \$301.68 |
| <b><u>NON PRACTISING FEES</u></b>  |          |
| Non practising membership  | \$46.00  |
| If lapsed  | \$57.50  |
| Non practising membership with membership in the Canadian Nurses Association | \$119.20 |
| If lapsed  | \$130.70 |

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.

| <b><u>TRANSFER FROM NON PRACTISING TO PRACTISING FEES</u></b>              |          |
|--|----------|
| <b>These fees include a credit for non practising fees previously paid</b> |          |
| December 1, 2021 - November 30, 2022                                       | \$536.65 |
| June 1, 2022 - November 30, 2022   | \$327.55 |
| September 1, 2022 - November 30, 2022                                      | \$198.18 |

(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).



**VERIFICATION OF 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

|                                       |                 |
|---------------------------------------|-----------------|
| <b><u>EXAMINATION INFORMATION</u></b> | CRNE            |
| Registration Examination:             | NCLEX           |
| Passing Score: _____                  | Other (specify) |
| Number of times written: _____        | _____           |

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

|  |             |               |
|--|-------------|---------------|
| <b>The applicant's registration / membership status for the past five years:</b> | <b>Year</b> | <b>Status</b> |
|  | _____       | _____         |
|  | _____       | _____         |
|  | _____       | _____         |
|  | _____       | _____         |

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

\_\_\_\_\_  
Date Printed name and Signature  
**Official Seal/Stamp**



**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

Jan 1 to Dec 31, \_\_\_\_ = \_\_\_\_ hours  
Year

Jan 1 to Dec 31, \_\_\_\_ = \_\_\_\_ hours  
Year

Jan 1 to Dec 31, \_\_\_\_ = \_\_\_\_ hours  
Year

Jan 1 to Dec 31, \_\_\_\_ = \_\_\_\_ hours  
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.**