



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

## APPLICATION FOR REINSTATEMENT OF REGISTRATION 2023

### 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 2022.

☐ 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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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

If you worked outside of NB since your last registration, and you are not actively registered elsewhere in Canada, a Confirmation of Hours of Work form must be completed by your employer(s) and sent directly to NANB.

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

#### **E. VERIFICATION OF CURRENT REGISTRATION**

If you are actively registered elsewhere in Canada, complete and submit the Confirmation of Active Registration form.  
If you are not actively registered in Canada, 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. PAYMENT**

Once your reinstatement request has been processed, you will be sent an invoice by e-mail. Once received, you can log into your My Profile account to pay this invoice using your credit card under the 'My Invoices' heading. You will be able to print your receipt once it is paid.



[www.nanb.nb.ca](http://www.nanb.nb.ca)

[www.aiinb.nb.ca](http://www.aiinb.nb.ca)

## CONFIRMATION OF ACTIVE REGISTRATION/ ATTESTATION D'IMMATRICULATION ACTIVE

This form is to be completed and returned by applicants/former members who currently hold an active registration and are licensed to practise in another Canadian province or territory.

Ce formulaire doit être rempli par toutes les personnes actuellement titulaires d'une immatriculation et d'un permis d'exercice valide ailleurs au Canada.

### **SECTION A:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Nom: (surname/nom de famille) (given names / prénoms) Date de naissance (day/jour – month/mois – year/année)

### **SECTION B:**

Please fill out the information below and return to NANB by e-mail at [nanbregistration@nanb.nb.ca](mailto:nanbregistration@nanb.nb.ca). If you are registered in more additional provinces than you have space for, please only include the jurisdictions with the latest expiry dates.

Veuillez fournir les renseignements ci-dessous puis envoyez le formulaire à [aiinbimmatriculation@aiinb.nb.ca](mailto:aiinbimmatriculation@aiinb.nb.ca). Si vous avez une immatriculation dans plus de provinces que le nombre de lignes, incluez seulement celles dont la validité restante est la plus longue.

Province of Registration / Province d'immatriculation	Registration number / Numéro d'immatriculation	Date of First Registration/ Date de première immatriculation	Date of Expiry / Date d'expiration

### **SECTION C:**

☐ I acknowledge that NANB may audit the information I provided here, and that I may be required to provide official proof of my registration in another Canadian province or territory at NANB's request.

Je comprends que l'AIINB peut vérifier les informations fournies ici et me demander de fournir une preuve officielle de mon immatriculation ailleurs au Canada.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT  
JE CERTIFIE QUE LES RENSEIGNEMENTS CI-HAUT SONT EXACTS

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

## 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 Nursing Regulatory Body and forwarded directly to NANB.)*

**Acting on behalf of** \_\_\_\_\_, **I do hereby certify that**  
Regulatory Body  
\_\_\_\_\_  
Name of applicant
a graduate of
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

Registration Examination:

Passing Score: \_\_\_\_\_

Number of times written: \_\_\_\_\_

☐ CRNE

☐ NCLEX

☐ Other (specify) \_\_\_\_\_

**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**



## **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.**