Nurses Association OF NEW BRUNSWICK Association des infirmières et infirmiers DU NOUVEAU-BRUNSWICK

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 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: _____/_____/_____ **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 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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Are you returning to work after leave of absence? ☐ Yes ☐ No If Yes From:_____ (dd/mm/yy) To:_____ (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. PAYMENT

Due to a change in our database and payment procedures, NANB will no longer accept manual payments sent by e-mail. Any credit card information that has previously been sent has been permanently deleted.

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.

Revised 2022-12-07

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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

_____**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
Registration Examination: ☐ CRNE ☐ NCLEX ☐ Other (specify)
Passing Score: _____
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

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.