

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: _____



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.



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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. If you are registered in more additional provinces than you have space for, please only include the jurisdictions with the latest expiry dates.

Veillez fournir les renseignements ci-dessous puis envoyez le formulaire à 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

_____ **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

<u>EXAMINATION INFORMATION</u>	
Registration Examination:	<input type="checkbox"/> CRNE
Passing Score: _____	<input type="checkbox"/> NCLEX
Number of times written: _____	<input type="checkbox"/> 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.