



ASSOCIATION OF NEW BRUNSWICK LICENSED PRACTICAL NURSES
384 SMYTHE STREET FREDERICTON NEW BRUNSWICK E3B 3E4
TELEPHONE: 506-453-0747 OR 1-800-942-0222 FAX:506-459-0503
WWW.ANBLPN.CA

VERIFICATION OF REGISTRATION: LICENSED PRACTICAL NURSE

How to complete this form:

Step 1: Applicant should complete Section 1

Step 2: The nursing board should complete Section 2

Step 3: The nursing board should return the fully completed form to ANBLPN by mail or email execdir@npls.ca

IMPORTANT: ANBLPN will not accept this document if sent by the applicant; it must be sent by the nursing board.

SECTION 1: TO BE COMPLETED BY APPLICANT

PERSONAL (Please Print)

_____	_____	_____
Current Legal Surname (Last Name)	Given Name (First Name)	Middle Name(s)
_____	_____	_____
Maiden Name	Date of Birth (DD/MM/YYYY)	Primary Language
_____	_____	_____
Mailing Address	City/Town/Village	Province
_____	_____	_____
Country	Postal Code/Zip Code	Telephone No.
_____	_____	_____
Mobile No.	Email Address	_____

EDUCATION & REGISTRATION (Please Print)

_____	_____	_____
Name of Nursing Program	Name of Educational Institution	Address of Educational Institution
_____	_____	_____
Graduation Date (dd/mm/yyyy)	Name of Registration/Nursing Board	Registration Number

I am seeking registration as a Licensed Practical Nurse in New Brunswick. I authorize _____ (name of registration/nursing board) to complete Section 2 of this form and mail the required documentation directly to the Association of New Brunswick Licensed Practical Nurses (ANBLPN).

Applicant's Signature

Date (dd/mm/yyyy)

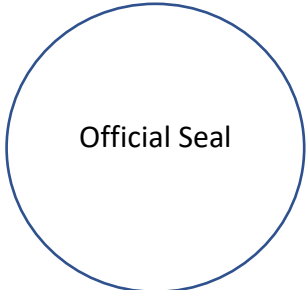


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SECTION 2: TO BE COMPLETED BY REGISTRATION/NURSING BOARD

_____ Current Legal Surname (Last Name)	_____ Given Name (First Name)	_____ Middle Name(s)
_____ Nursing Educational Program		_____ Completion Date (dd/mm/yyyy)
_____ Registered by <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement		
_____ Educational Facility Address		
_____ Initial Registration Date	_____ Expiry Date	_____ Registration No.
_____ Name of Examination Written	_____ Date Examination Written	_____ Language of Examination
Results Pass <input type="checkbox"/> Fail <input type="checkbox"/>	Current Status <input type="checkbox"/> Registered <input type="checkbox"/> Inactive	

1. Has the applicant's registration ever been revoked, suspended, or under review?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Has the applicant's registration ever been made subject to conditions, limitations, restrictions, and/or an agreement with the board?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has the applicant ever voluntarily surrendered their registration with the board and/or any other jurisdiction?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Has the applicant ever been denied registration?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have there ever been any formal sanctions imposed against the applicant as a matter of public record?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Is the applicant the subject of a current investigation, proceeding, outstanding, and/or unresolved complaint against them in relation to their practice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "YES" is the answer to any of the questions, please attach documentation outlining action(s) taken.		

_____ Signature of Registrar & Title	_____ Print Name	
_____ Date (dd/mm/yyyy)	_____ Name of Licensing Authority	

