



155 Belvedere Avenue, Suite 204  
Charlottetown, PE  
C1A 2Y9

**VERIFICATION OF REGISTRATION FORM**

You must provide registration information from the licensed practical nursing and / or registered practical nursing regulatory authority (s) where you are currently licensed / registered and where you were previously licensed/ registered.

**SECTION A: THIS SECTION TO BE COMPLETED BY THE APPLICANT**

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Previous Legal Last Name(s): \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

I hereby authorize the regulatory authority \_\_\_\_\_

in the province of \_\_\_\_\_ to send the required

documentation directly to the PEI Licensed Practical Nurses Registration Board.

Signature of Applicant \_\_\_\_\_

**SECTION B: THIS SECTION TO BE COMPLETED BY THE REGISTRAR OR DESIGNATE**

Name of nursing school/nursing education institution: \_\_\_\_\_

Location of nursing school: (City, Province/State, Country) \_\_\_\_\_

Program start date: (MM/DD/YYYY) \_\_\_\_\_

Completion/Graduation date: (MM/DD/YYYY) \_\_\_\_\_

Transcripts received: YES \_\_\_ NO \_\_\_ Transcript date: (MM/DD/YYYY) \_\_\_\_\_

Name of nursing program: \_\_\_\_\_

Type of program completed: Diploma \_\_\_ Degree \_\_\_ Other: \_\_\_\_\_

Name of credential obtained: Practical Nurse \_\_\_ Registered Nurse \_\_\_ Associate \_\_\_

Nurse registration/licence number: \_\_\_\_\_

Date first registration/licence issued: (MM/DD/YYYY) \_\_\_\_\_

Date registration/licence expires or expired: (MM/DD/YYYY) \_\_\_\_\_

Method by which registered: Examination \_\_\_ Endorsement \_\_\_

Type of nursing registration/licensing examination: CPNRE \_\_\_ NCLEX \_\_\_ Provincial exam \_\_\_

Date passed examination: (MM/DD/YYYY) \_\_\_\_\_

Registration/Licence type: Active Practicing Conditional Inactive

Registration/Licence Status: Current Expired

Nursing registration/license is the subject of a current investigation, outstanding and/or unresolved complaint related to nursing practice? YES \_\_\_ NO \_\_\_

If yes, explain:

Nursing registration/licence ever encumbered, suspended, surrendered, revoked or denied?

YES \_\_\_ NO \_\_\_

If yes, explain:

Any current limitations/conditions/restrictions on nursing registration/license whether voluntary or not?

YES \_\_\_ NO \_\_\_

If yes, explain:

### **SECTION C: AUTHORIZATION**

Jurisdiction: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_

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