



APPLICATION FOR NEW NURSE REGISTRATION

R3

Website: <https://fnc.org.fj>
 Email: kelera.batibasaga@fnc.org.fj
 Phone: (679) 9980595

(Under Nursing Decree 41 of 2011)
 Please complete all sections of this form. Tick boxes
 where applicable

4.5 x 3.5
 Glue recent valid ID photo

1. PERSONAL INFORMATION

First Name: <input type="text"/> Other Name(s): <input type="text"/> Last Name: <input type="text"/>	New FNC Registration Number: <input type="text"/> Employment Number: <input type="text"/>
Date of Birth: <input type="text"/> <i>DD/MM/YYYY</i> Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Country of Citizenship: <input type="text"/> Country of Birth: <input type="text"/>
Residential Address: <input type="text"/> <input type="text"/> <input type="text"/>	Postal Address: <input type="text"/> <input type="text"/> <input type="text"/>
Employer Details: Employer Name: <input type="text"/> Employer Address: <input type="text"/> <input type="text"/> Phone Contact: <input type="text"/> Department/Ward: <input type="text"/>	
Name of next of kin: <input type="text"/> Relationship: <input type="text"/> Address of next of kin: <input type="text"/> Mobile Contact: <input type="text"/> Landline Contact: <input type="text"/> Language: <input type="text"/>	

2. NURSING REGISTRATION HELD IN FIJI AND ELSEWHERE

Date of entry	Registering Authority	Name of Nation/State	Valid Until	General / Specialist
<i>DD/MM/YYYY</i>	<input type="text"/>	<input type="text"/>	<i>DD/MM/YYYY</i>	<input type="text"/>

3. REGISTRATION DETAILS

Category(s) of Registration sought:

Internship
 General Registration
 Vocational

Vocational registration in the field of



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4. PRIMARY NURSING QUALIFICATION
Qualification gained:
Institution:
Country:
Year & length of program:
Clinical instruction received:
Language of instruction of course:

5. INTERNSHIP TRAINING COMPLETED AS FOLLOWS			
Clinical Discipline	Institution & location Name of hospital & city	Duration (In Months)	Month/Year Completed
General Medical & Surgical Nursing			
Psychiatry Nursing			
Obstetrics & Gynecology			
Public Health			
Other			

6. SUMMARY RECORD OF NURSING PRACTICE (FROM INITIAL QUALIFICATION UNTIL THE PRESENT)					
Any period of unemployment or temporary retirement from practice greater than one month should be documented and reasons for same indicated. Attach additional sheets if necessary. Please do not simply write "See C.V."					
	From: <i>MM/YYYY</i>	Until: <i>MM/YYYY</i>	Post:	Location (Name of hospital)	Clinical area of practice
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					



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7. DECLARATION BY APPLICANT

- I undertake to display my annual practicing license card in the public area of my practice and ensure that patients are aware of the status and conditions.
- I undertake to comply with all relevant legislation and Council guidelines, regulations, codes & standards.
- I undertake to provide the Council police clearance reports from all jurisdictions should the Council seek such documents.
- I undertake to provide the Council medical reports should the Council seek such documents.
- I undertake to inform the Council within 30 days should any of the details change stated in this form.
- I undertake to cooperate with the Council in all matters including complaints and disciplinary.
- I consent to the Registrar divulging relevant practice details as it sees fit.
- I consent to the Registrar verifying any information provided by me in this form.
- I declare that I am fit for practice in the vocation I am applying for.
- I make this declaration in the knowledge that a false statement may amount to perjury and revoke my practice certificate.
- I solemnly declare to the best of my knowledge that all information provided are true and correct.
- I undertake to uphold the nursing profession in high esteem.

Signature:

Date: DD/MM/YYYY

8. SUPPORTING DOCUMENTS

Please submit copies of the following documents with this application:

- | | |
|---|--------------------------|
| 1 Recent Passport Sized Photo | <input type="checkbox"/> |
| Certified copy of Birth Certificate | <input type="checkbox"/> |
| Certified copy of Basic or Undergraduate Nursing qualification(s) | <input type="checkbox"/> |
| Certified copy of Postgraduate qualification. | <input type="checkbox"/> |
| Certified copy of Registration Examination result(s) | <input type="checkbox"/> |
| Fee Payment Receipt [Resident: \$48.00] | <input type="checkbox"/> |

False/Fraudulent claims: In the event of any applicant submitting false or incomplete information, and/or copies of certificates, which are found to be false, the Nursing Registration authority of the applicant's citizenship will be notified. The application for registration in Fiji will not be granted; or provisional registration, if already given, will not be confirmed, and may be cancelled. Council may require further information before such decision is made.



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9. PAYMENTS

A fee schedule can be viewed on our website. Please make any cheques payable to the Registrar of the Fiji Nursing Council. Should you wish to make a direct payment, **add your details in the payer section** and deposit the fee in our BSP Account (AC #: 8686863, BSP Swift Code: BOSPFJFJ).

Preferred Method of Payment

Direct Deposit to BSP Account [AC #: 8686863, BSP Swift Code: BOSPFJFJ]

<u>Description</u>	<u>Rate (FJD\$) - VIP</u>
Application fee registration – resident	\$48.00 FJD
Application fee registration – nonresident	\$120.00 FJD

10. OFFICIAL USE ONLY

Receiving Officer Name:

Receiving Officer Signature:

Date received: DD/MM/YYYY

Receipt Number:

Comments:

Complete Incomplete

Approved Not Approved

Payment Received: RR Amount (\$): Date: DD/MM/YYYY

All applications should be addressed to the:

**Director
Fiji Nursing Council,
1 High Street,
Toorak SUVA.**