



RENEWAL OF LICENSE - REGISTERED NURSE

R4A

4.5 x 3.5
Glue recent valid ID photo

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

(Provision under the Nursing Act 2011)
Please complete all sections of this form. Tick boxes where applicable.

1. PERSONAL INFORMATION	
First Name	Tax Identification No:
Other Name (s):	FNPF Number:
Last Names:	FNC Registration Number:
Date of Birth:	Employment Number:
Postal Address:	Telephone Contact: Mobile: Landline (Home):

2. EMPLOYMENT & CURRENT PLACE OF PRACTICE	
Name of Employer:	
Employer Address:	
Phone Contact:	Department/Ward:

3. REGISTRATION DETAILS	
Category of License Sought:	
General Nurse	<input type="checkbox"/>
Vocational:	
Midwife	<input type="checkbox"/>
Nurse Practitioner	<input type="checkbox"/>

4. SUMMARY OF PRACTICE IN THE LAST YEAR			
Date	Station/Location	Position	Duties/Responsibilities
<i>DD/MM/YYYY</i>			
<i>DD/MM/YYYY</i>			
<i>DD/MM/YYYY</i>			

5. OTHER QUALIFICATIONS GAINED IN THE LAST YEAR	
Qualification:	Language of Instruction:
Qualification:	Language of Instruction:
Qualification:	Language of Instruction:



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6. 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 document.
- I undertake to provide the Council medical reports should the Council seek such document.
- I undertake to inform the Council within 30 days should any of the details change stated on 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 of my practicing certificate.
- I solemnly declare to the best of my knowledge that all information provided are true & correct.
- I undertake to uphold the Nursing profession in high esteem.

Signature: _____

Date: DD/MM/YYYY

7. PAYMENT DETAILS

*We only encourage direct BANK payment, add your details in the payer section & deposit the fee in our BSP account # 8686863.
BSP Swift Code: BOSPFJFJ.*

Amount deposited: \$80.00 FJD

8. CHECKLIST

Certified copy of Birth Certificate
Certified copy of evidence of 20 CPD points achieved
Certified copy of previous APL
Evidence of Payment receipt [\$80.00 FJD]

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Note: Additional supporting Document to include a Police Report or Statutory Declaration for missing APL card

9. OFFICIAL USE ONLY

Receiving Officer
Name: _____

Receiving Officer
Signature: _____

Date received: DD/MM/YYYY

Receipt Number: _____

Approved:

Not Approved:

Payments Received: RR _____

Amount (\$): _____

Date: DD/MM/YYYY

License Dispatched Date: DD/MM/YYYY