



REGISTRATION - CONDITIONAL LICENSE - NURSING INTERN

R4D

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

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

4.5 x 3.5
Glue recent valid ID photo

1. PERSONAL INFORMATION

First Name: <input type="text"/>	Title: Mr. <input type="checkbox"/>	FNC Number: <input type="text"/>
Other Name(s): <input type="text"/>	Miss. <input type="checkbox"/>	Employment Number: <input type="text"/>
Last Name: <input type="text"/>	Mrs. <input type="checkbox"/>	
Date of Birth: <input type="text"/> <i>DD/MM/YYYY</i>	Country of Citizenship: <input type="text"/>	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Country of Birth: <input type="text"/>	
Residential Address: <input type="text"/>	Postal Address: <input type="text"/>	

EMPLOYER DETAILS

Employer Name: <input type="text"/>	
Employer Address: <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>			<i>DD/MM/YYYY</i>	

3. REGISTRATION DETAILS

Category(s) of Registration sought: Internship <input type="checkbox"/> General Registration <input type="checkbox"/> Vocational <input type="checkbox"/>
Vocational registration in the field of <input type="text"/>



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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 (FOR THE PREVIOUS 5 YEARS)

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: MM/YYYY	Until: MM/YYYY	Post:	Location (Name of hospital)	Clinical area of practice
1					
2					
3					
4					
5					
6					
7					
8					
9					

Signature of applicant: _____

Date: DD/MM/YYYY

7. 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]

Description

Rate (FJD\$) - VIP

Application fee registration

\$80.00 FJD



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8. SUPPORTING DOCUMENTS

Please submit copies of the following documents with this application:

Certified copy of Birth Certificate	<input type="checkbox"/>
Certified copy of Bachelor of Nursing Certificate	<input type="checkbox"/>
1 Recent Passport Sized Photo	<input type="checkbox"/>
Certified copy of Registration Examination result(s)	<input type="checkbox"/>
Confirmation letter for successful completion of Internship program	<input type="checkbox"/>
Evidence of payment slip/receipt of \$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.

9. OFFICIAL USE ONLY

Receiving Officer
Name:

Receiving Officer
Signature:

Date received: DD/MM/YYYY

Receipt Number:

Comments:

Complete Incomplete

Approved Not Approved

Payments Received: RR

Amount (\$):

Date: DD/MM/YYYY

Date Issued: DD/MM/YYYY

All applications should be addressed to the:

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