RENEWAL OF LICENSE - REGISTERED NURSE PRACTITIONER

R4C

Website: https://www.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.

4.5 x 3.5
Glue recent valid ID photo

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:	
Position:	Years of Service:
Work Address:	

3. REGISTRATION DETAILS

Category of License Sought:

General Nurse ☐

Vocational:

Midwife ☐ Nurse Practitioner ☐

4. SUMMARY OF PRACTICE IN THE LAST YEAR

Date	Station/Location	Position	Duties/Responsibilities
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			

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

For direct online BANK payment, add your FNC number in the payer section & deposit the fee in our BSP account # 8686863, Swift Code: BOSPFJFJ

Amount deposited: $112.00 FJD ☐

Payments may be made via internet banking, M-PAiSA, MyCash or SOLE to FNC's BSP account, quoting your FNC number as reference. Print and attach the payment confirmation with your application submission

8. CHECKLIST

Certified copy of evidence of 20 CPD points achieved ☐
Certified copy of previous APL ☐
Online fee payment confirmation receipt [$112.00 FJD] ☐
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*