TEMPORARY NURSING REGISTRATION

R5

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

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

1. PERSONAL INFORMATION

First Name:
Other Name(s):
Last Name:

TITLE
Mr. ☐
Miss. ☐
Mrs. ☐

Residential Address:

Postal Address:

EMPLOYER DETAILS

Employer Name:
Employer Address:
Phone Contact: Department/Ward:

Passport Number: Driving License Number:

Name of next of kin: Relationship:
Address of next of kin:
Mobile Contact: Landline Contact:
Language:

2. NURSING REGISTRATION HELD

Date of entry	Registering Authority	Name of Nation/State	Valid Until	General / Specialist
DD/MM/YYYY			DD/MM/YYYY	
DD/MM/YYYY			DD/MM/YYYY	
DD/MM/YYYY			DD/MM/YYYY	

3. TEMPORARY REGISTRATION

Category(s) of Registration sought:

Internship ☐ General Registration ☐ Vocational ☐

Dates: From DD/MM/YYYY until DD/MM/YYYY *(Relevant to specific duration less than 3 months)*

Reason for seeking temporary registration: *(Give name of sponsoring agency, place of practice, details of project/or any other reason)*

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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			
Psychiatric Nursing			
Obstetrics & Gynecology			
Public Health			
Other			

6. POSTGRADUATE DEGREE(S)/CERTIFICATION(S)

DATE	DIPLOMA/DEGREE	Full Name and Location of Conferring Authority
YYYY/MM		
YYYY/MM		
YYYY/MM		

7. ADDITIONAL QUALIFICATION(S)

8. DISCIPLINARY ENQUIRIES & CHARGES (PENDING/CONCLUDED)

DATE	COUNTRY	DETAILS
YYYY/MM		
YYYY/MM		
YYYY/MM		

9. CURRENT LOCATION AND SPHERE OF NURSING PRACTICE

Including hospital/academic appointments, give full name and address of employing authority, or, if relevant name of partners in private or state: "Solo Practice"
Name:
Address:

10. PROFESSIONAL INDEMNITY

Do you have professional indemnity cover insurance that will be applicable whilst you practice in Fiji?
Yes ☐ No ☐
If yes, provide details and evidence:

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11. OTHER MATTERS

Are you currently facing any criminal or traffic charges? Yes ☐ No ☐
If yes, provide details and evidence:

12. DECLARATION BY APPLICANT

- I undertake to display my temporary practicing certificate 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*

13. SUPPORTING DOCUMENTS

Please submit copies of the following documents with this application:

Certified copy of Basic or Undergraduate Nursing qualification	
Certified copy of Postgraduate qualification	
Certified copy of passport biodata	
Certificate of Good Standing from the Nursing Council authority/recent place of Nursing practice, date not more than 3 months.	
Evidence of Professional indemnity	
Evidence of Continuing Professional Development	
1 Recent Passport Sized Photo	
Online fee payment confirmation receipt	
MoH approval for Medical Team Visit (Overseas)	

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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14. PAYMENTS

Please make any cheques payable to the Registrar of the Fiji Nursing Council. You can make an online payment by **adding your FNC details in the payer section** and deposit the fee in our BSP Account (**AC #: 8686863, BSP Swift Code: BOSPFJFJ**).

Description	**Rate (FJD$) - VIP**
Application for Temporary Registration [Overseas Visiting Teams]	$112.00 FJD
Application by Overseas Applicants for General Nursing Registration [Non-Resident]	$160.00 FJD
Application for Annual Practicing Licensure for Vocational/General Nursing [Non-Resident]	$200.00 FJD

Payments may be made ONLY 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.

15. OFFICIAL USE ONLY

Receiving Officer Name: Receiving Officer Signature:

Date: DD/MM/YYYY

Comments:

Complete ☐ Incomplete ☐

Approved ☐ Not Approved ☐

Receipt Number:

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

All applications should be addressed to the:

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