



VERIFICATION OF REGISTRATION / LICENSURE

SECTION A: TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE COUNCIL / BOARD OF NURSING WHERE ORIGINAL REGISTRATION WAS OBTAINED

Miss, Mrs., Mr. _____

Address _____

Graduated From _____

Birth Date _____ Nationality _____

Date of Registration _____ Registration No _____

SIGNATURE

DATE

Section B: To be completed by an Officer of the Registration Authority.

To the Registration Section, NURSING AND MIDWIFERY COUNCIL OF GHANA.
P. O. Box MB44, ACCRA, GHANA.

ACTION ON BEHALF OF THE _____

Name of the Council for Registration of the Nurse/Midwife where applicant has recently registered.

I do certify that _____

Name of Applicant

GRADUATE OF _____

(School of Nursing)

(Location in City / Country)

Was issued a Certificate or Registration as a _____

BEARING THE NUMBER _____ DAY _____ MONTH _____ YEAR _____

Registration was obtained by Examination Yes No If 'No'

How _____

The Certificate is Current. Yes No If 'No' indicate Registration for renewal on Reverse side.

Has the Certificate License ever been revoked? Yes No

If yes, please indicate the reason on reverse side.

Details of Registration examination Taken with Scores obtained.

1. Medical Nursing _____
2. Surgical Nursing _____
3. Obstetric Nursing _____
4. Paediatric Nursing _____
5. Geriatric Nursing / Care of the elderly _____
6. Psychiatric Nursing _____
7. Home Nursing _____
8. Practical Nursing _____
9. Comprehensive Programme _____
10. Passing Scores _____

SEAL

Secretary /Registrar

DATE