

Address to which your registration certificate should be posted (if different):

| | | | | | |
|----------|--|--|--|--|--|
| | | | | | <p>NOTE: Enter the postal address to which your registration certificate and/or any correspondence in connection with this application should be sent.</p> <p>The address details entered here will <u>not</u> be recorded in the register.</p> |
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| | | | | | |
| Postcode | | | | | |

Contact Details:

| | | | | | | | | | | | | | | |
|-------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Telephone Number (home) | | | | | | | | | | | | | | |
| Telephone Number (work) | | | | | | | | | | | | | | |
| Cellphone Number | | | | | | | | | | | | | | |
| Fax Number | | | | | | | | | | | | | | |
| E-mail Address | | | | | | | | | | | | | | |

Qualification Details:

| | | | | | | | | | | | | | | |
|---|--------------|--|--|--|---|---|---|---|---|---|---|---|---|---|
| Country Where Qualification Issued | | | | | | | | | | | | | | |
| Name of Nursing Education Institution | | | | | | | | | | | | | | |
| Name of Qualification | | | | | | | | | | | | | | |
| Date Qualification Issued | (yyyy-mm-dd) | | | | Y | Y | Y | Y | - | M | M | - | D | D |
| Name of Regulatory Body in Country Where Issued | | | | | | | | | | | | | | |
| Details of Legislation (under which qualification was issued – if applicable) | | | | | | | | | | | | | | |

Details of Community Service:

| | | | | | | | | | | | | | | |
|---|--------------|--|--|--|---|---|---|---|---|---|---|---|---|---|
| Name of Health Establishment (where Community Service will be performed) | | | | | | | | | | | | | | |
| Name of Town / City | | | | | | | | | | | | | | |
| Province | | | | | | | | | | | | | | |
| Date of Commencement of Community Service | (yyyy-mm-dd) | | | | Y | Y | Y | Y | - | M | M | - | D | D |

Signed by Applicant:

| | | | | | | | | | | | | | | |
|---|--------------|--|--|--|---|---|---|---|---|---|---|---|---|---|
| I certify that the information provided in this application is true and correct | | | | | | | | | | | | | | |
| Signature | | | | | | | | | | | | | | |
| Date | (yyyy-mm-dd) | | | | Y | Y | Y | Y | - | M | M | - | D | D |

Please note that when this form is submitted to the Nursing Council it must be accompanied by the following items:

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|--|
| 1. <u>Certified</u> copy of applicants identity document or passport |
| 2. Registration fee of R150-00 (including VAT) or proof of payment |

| FOR OFFICE USE ONLY | |
|---------------------|----------------|
| Check | Card |
| | Cash |
| | Cheque |
| | Direct deposit |
| | Postal Order |