Registered Nurses Association
of the Northwest Territories and Nunavut
Phone: (867) 873-2745 / Fax: (867) 873-2336 / Email: info@rnantnu.ca
P.O Box 2757, Yellowknife, NT X1A 2R1

VERIFICATION REQUEST FORM

INSTRUCTIONS: Applicants must complete Part A of this form and forward a copy to the regulatory body in which you have been registered/licensed.

Part A: Please Print

Name: _____ _____ _____
Last Name First Name Middle Name (Underline Common Name) Previous Name(s)

Phone: (_____) _____ Email: _____

Address: _____
Number Street City/Town Province/Territory Postal Code

Date of Birth (YYYY/MM/DD): _____ RNANT/NU Registration Number: _____

INITIAL NURSING EDUCATION

School where you completed our basic program: _____

Date of Graduation (MM/YY): _____ Initial Nurse Registration Date (/MM/YYYY) _____

Signature: _____ Date: _____

Part B: (*For Regulatory Body only*)
Complete Part B of this form and submit it to the RNANT/NU office by email, fax or mail.

Name of regulatory body: _____

Name of Registrant: _____ Registration Number: _____

Type of Registration Granted (Designation): _____

Initial Registration Date (DD/MM/YYYY): _____ Expiry Date (DD/MM/YYY): _____

Registered by (Check one): ☐ Examination ☐ Endorsement

Has this person's registration/license ever been denied, revoked, suspended or under review? ☐ Yes ☐ No

Examination Written: _____ Number of Writings: _____

Date Exam Passed (DD/MM/YYYY): _____ Passing Score: _____

Name of Registrar/Individual completing form: _____ Title: _____

Signature: _____ Date: _____

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