CARNA College & Association of Registered Nurses of Alberta

VERIFICATION OF NURSE REGISTRATION REQUEST FORM

Applicant Instructions

1. Complete the personal information on this page and sign the consent section.
2. Forward this request form to the jurisdiction from which you are requesting verification of registration.

Verification documents must come directly to CARNA from the nursing registration body or licensing authority.

Name _____
Last or Family name(s) *Given name(s)* *Previous name(s) if applicable*

Email address _____

Address _____
Apartment and/or House Number and Street Address

_____
City *Province/State/Territory* *Country* *Postal Code*

Phone (_ _____) _____ (_ _____) _____
Area Code *Home* *Area Code* *Cell*

School of Nursing _____
Print Full Name of School (do not abbreviate)

School of Nursing Address _____
City *Province/State/Territory* *Country*

Graduation Date _____/_____/_____ Birthdate _____/_____/_____
Day *Month* *Year* *Day* *Month* *Year*

Registration Number _____ Initial Registration Date _____/_____/_____
with ***this*** Jurisdiction with ***this*** Jurisdiction *Day* *Month* *Year*

Consent

I hereby give consent for completion of this *Verification of Nurse Registration* request form concerning my registration status with _

_____
.
Name of nursing jurisdiction

_____ _____
Signature of Applicant Date

Instructions for Regulatory/Licensing Authority are on page 2

780.451.0043 | 1.800.252.9392
nurses.ab.ca

11120 178 St. NW
Edmonton, AB T5S 1P2

VERIFICATION OF NURSE REGISTRATION STATUS

TO BE COMPLETED BY NURSING JURISDICTION ONLY

- **Verifications will be rejected if correction fluid or tape is used.**
- **The delivery method (email/envelope/fax) must clearly show that the verification was sent from the regulatory/licensing authority directly to the College and Association of Registered Nurses of Alberta (CARNA) and that the document was not handled by the applicant or an agent of the applicant.**

This will certify that:

_____

Last or Family name(s) *Given name(s)* *Previous name(s) if applicable*

Birthdate _____/_____/_____ completed a nursing education program on _____/_____/_____
Day Month Year *Day Month Year*

at _____
School of Nursing

_____
City *Province/State/Territory* *Country*

and was registered to practice as a _____ Registration Number _____

Initial Registration Date _____/_____/_____ Current status is: ☐ Registered ☐ Inactive
Day Month Year

Permit/License Expiry Date _____/_____/_____ Registration was by: ☐ Examination ☐ Endorsement
Day Month Year

Name of examination written:
☐ CNA Testing Services
☐ NLN State Board Test Pool
☐ NCLEX-RN
☐ Other(specify) _____

Language of examination: ☐ English ☐ Other _____

Number of times examination written _____

Passing Score _____

Is this person currently undergoing an investigation or subject to an unprofessional conduct or disciplinary process?
☐ Yes* ☐ No *If "Yes" please attach documentation outlining action taken.*

Has this person's registration/license ever been revoked, suspended or under review?
☐ Yes* ☐ No *If "Yes" please attach documentation outlining action taken.*

Place Official Seal or Stamp Here

_____ _____
Signature *Date*

_____ _____
Name *Title*

_____
Name of Regulatory / Licensing Authority

_____ _____
Email *Phone*