

GENERAL NURSING COUNCIL OF SAINT LUCIA

**APPLICATION FORM
RE-REGISTRATION/LICENSURE**

SECTION A

NAME: Surname _____ First _____ Middle _____

Marital Status S () M () D () W () Maiden Name _____
Tick appropriate box

Professional Status: _____ **License No/s.**

Address: **Work:** _____ **Phone No:** _____

Home: _____ **Phone No:** _____

SECTION B

Continuing Education:

Please briefly describe below the learning activities and state the number hours of each activity which you have undertaken to demonstrate compliance with Continuing Education of a minimum of 15 HOURS.

Date _____	Hours
Date _____	Hours
Date _____	Hours
Date _____	Hours
Date _____	Hours
Date _____	Hours
Date _____	Hours
Date _____	Hours

TOTAL HOURS: _____

Signature of Applicant: _____ **Date:** _____

Print Name of Head of Dept /Supervisor: _____

Signature of Supervisor: _____ **Date:** _____