



INAMA Y'IGIHUGU Y'ABAFOROMOKAZI, ABAFOROMO N'ABABYAZA
NATIONAL COUNCIL OF NURSES AND MIDWIVES
CONSEIL NATIONAL DES INFIRMIERES, INFIRMIERS ET DES SAGES-FEMMES
P.O BOX 4259 KIGALI MOB. TEL: (250) 0788386969 E-mail: info@ncnm.rw

Verification of Registration/Licensing Request

A. To be completed by applicant

Surname and first name
Other names Date of Birth/...../.....
Professional title: Registration /License No
National ID/Passport:.....

Personal address:

Name: Street:
District: Province:
Country:Postal Code (if applicable)
E-mail address:Tél:.....

Professional address:

Employer's name/ title:
Street: District:
Province: Postal Code:

B. To be Completed by Registration/Licensing Authority

Professional Information

This is to certify thatborn/...../.....was issued with registration certificate/ license numberon/...../..... as aThe license will expire/ expired on/...../20....

The certificate/licensing was issued: by endorsement on passing state examination licensing examination
other please, specify:

Has the license ever been revoked? Suspended? Restricted? (if so, please specify reason)

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.....

Registration/Licensing authority:Title

Name: Signature.....

Seal or Official stamp