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: ncnm.cnisf@gmail.com

Verification of Registration/Licensing Request

A. To be completed by applicant

Surname and first name .....

Other names ..... Date of Birth ...../...../.....

Professional title: ..... Registration /License № .....

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 that .....born ...../...../.....was issued with registration certificate/ license number .....on ...../...../..... as a ....The 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Has the license ever been revoked?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