CRPNS
COLLEGE OF
REGISTERED PSYCHIATRIC NURSES
OF SASKATCHEWAN

R-02a

Verification of Registration

SECTION A – PERSONAL INFORMATION

To be completed by APPLICANT and forwarded to current or most recent regulatory body.

Full Name: _____
Surname *Given Name(s)* *Middle*

Other Name(s) (your last/family names at birth, your maiden name, or any other former/current names used)**:** _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *Province* *Postal Code* *Country*

CRPNS Registration: _____ **Date of Birth:** _____
Note: If you do not have a Sask license number leave blank *mm-dd-yyyy*

If you belong to a profession other than psychiatric nursing, please fill out form R-02b

I give my consent to you, to provide the information requested in sections B – D of this form directly to the College of Registered Psychiatric Nurses of Saskatchewan (CRPNS).

Signature: _____ **Date:** _____

Email Address: _____ **Phone #:** _____

SECTION B – CURRENT REGISTRANTS

To be completed by the REGULATORY BODY and forwarded directly to CRPNS.
Please provide the following information concerning the above-named psychiatric nurse.

Registration Number: _____ **Date Issued:** _____ **Valid to/Expired:** _____
mm-dd-yyyy *mm-dd-yyyy*

Current status of Applicant's registration: Practicing ☐ Non-Practicing ☐ GPN ☐ Inactive ☐

Method by which the Applicant was registered: Examination ☐ Endorsement ☐

Date Applicant passed a registration/licensing exam? _____
mm-dd-yyyy

Please provide detail for the past 5 years, most recent first.

Years:					
Hours:					

Are these hours self-reported? Yes ☐ No ☐

Does this applicant meet the hours requirement in your jurisdiction? Yes ☐ No ☐

SECTION C – ELIGIBLE TO REGISTER

Please provide the following information for students and graduate applicants.

The above named has successfully completed an approved program in psychiatric nursing at:

_____

Name of School *Date Completed (mm-dd-yyyy)*

Is the applicant eligible for registration in your jurisdiction? Practicing ☐ GPN ☐ No ☐

Has the applicant registered for the RPNCE? Yes ☐ No ☐

Location:_____ **Date** (mm/dd/yyyy):_____

Has the applicant passed the registration/licensing exam? Yes ☐ No ☐

Date Applicant passed a registration/licensing exam (mm/dd/yyyy):_____

SECTION D – ALL REGISTRANTS

Does this psychiatric nurse have any current conditions or limitations on their registration?	Yes ☐ No ☐
Is this psychiatric nurse currently under investigation?	Yes ☐ No ☐
Has the registration/license of this psychiatric nurse ever been encumbered, revoked, suspended or denied?	Yes ☐ No ☐
Does this psychiatric nurse have a physical/mental condition, disorder and/or any substance use disorder, that impairs their ability to practice?	Yes ☐ No ☐

If you answered "Yes" to any of the above questions, please attach additional details on a separate piece of paper.

Full Name: _____ **Title:** _____

Please print your complete name *Please indicate your official title*

Phone Number: _____ **Email:** _____

Including country code if outside Canada

SEAL

Signature: _____ **Date:** _____

mm-dd-yyyy