



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 <input type="checkbox"/> No <input type="checkbox"/>
Is this psychiatric nurse currently under investigation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the registration/license of this psychiatric nurse ever been encumbered, revoked, suspended or denied?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does this psychiatric nurse have a physical/mental condition, disorder and/or any substance use disorder, that impairs their ability to practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>

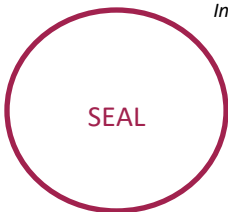
If you answered "Yes" to any of the above questions, please attach additional details on a separate piece of paper.

Full Name: _____
Please print your complete name

Title: _____
Please indicate your official title

Phone Number: _____
Including country code if outside Canada

Email: _____



Signature: _____ Date: _____
mm-dd-yyyy