

NURSING COUNCIL

COMMONWEALTH OF THE BAHAMAS

Virginia and Augusta Streets

Nassau, Bahamas

Post Office Box: N-8506

Telephone Number: 1-242-604-6015 / 1-242-604-6017

Email: [info@nursingcouncilbahamas.com](mailto:info@nursingcouncilbahamas.com)

|  |
| --- |
| **NURSING COUNCIL**  **INDEX NUMBER** |

Attach Photo here

INDEX OF CLINICAL STUDENTS

…………………………………………………………………………………………………………………………………

Surname **(Block Letters)** First Middle Maiden

Date of Birth …………………………………………….. Postal Address……………………….……………………

Telephone Number……………………………………Email……………………………………………….…………

Permanent Address ……………………………………………..……………………………………………………….…….……………………..

……………………………………………………………………………………….………………………………………….

Educational Qualifications

|  |  |  |
| --- | --- | --- |
| **cERTIFICATES** | **#** | **list SUBJECTS** |
| b.j.c |  |  |
| G.C.E |  |  |
| B.G.C.S.E. |  |  |
| R.S.A |  |  |
| Pitman |  |  |
| Others |  |  |

**Certified copies of the above documents must be submitted along with:**

1. **College Preparatory Transcript 5. Birth Certificate (digital)**
2. **Medical Certificate 6. First four pages of Passport**
3. **A Character Reference 7. Marriage Certificate if applicable**
4. **Police Character Certificate 8. Photo I. D.**

Date of Interview ……………………………………………..

State Programme under which Nursing Student is to study………………………………………………..….………

…………………………………………………………………………………………………………………………………

Length of Study ……………………………………………………………………………………..

Date of Commencement of Study…………………………………………………………………

**i.e. date on which Nursing Programme commenced (The Nursing Student must enter at the beginning and must complete the full programme)**

Name of School………………………………………………………………………………………………………………

Affiliated Facilities……………………………………………………………………………………………………………

I hereby declare that I am medically fit and that the foregoing particulars are in every respect correct and true. The fee of fifteen dollars ($15.00) is hereby submitted.

Signature of Nursing Student …………………………………………….......... Date…………………………….…....

Signature of Coordinator Nursing Programme ……………………………...… Date …………………………………

Signature of Chairperson of the Division of Nursing …….…………………… Date …………………………………

Registrar ……………………………………………………………………..…… Date …………………………..……..

|  |
| --- |
| Receipt Number |

Nursing Council, Commonwealth of The Bahamas

Revised May, 2022