Out Patients Department
Level 1
St. Luke's Hospital
G'Mangia

Application for Registration as a Nurse

Fill all sections in this form with Black ink

Surname _____ Full Name _____

Maiden Surname _____ Status _____

Address _____

_____

Telephone /Mobile Numbers: _____

E-Mail Address: _____

Passport or Identity Card Number: _____

Date of Birth: _ /_ / __ Nationality: _____

Qualification: _____

Name of Educational Institute: _____

Address of Educational Institute: _____

_____

Date course was commenced: _____

Date of Qualification: _____

Professional Registration Authority: _____

Address of Professional Registration Authority: _____

_____

Disclaimer: Information Protected - personal information provided on this form is protected & used in accordance with the Data Protection Act (Cap 440 of the laws of Malta) & Health Care Professions Act (Cap 464 of the laws of Malta)

Are you registered or have you applied for registration with another Health Care Professions' Council? If yes, kindly give details _____

DECLARATION OF APPLICANT

I bind myself and declare that in the event of being registered to the Code of Ethics for Nurses and Midwives and any instructions or directives that may be issued by CNM during the currency of my registration.

I bind myself to inform the Council of any changes regarding the information given within one week of its occurrence

I declare that the information given is accurate and complete as per the Registration Guidelines.

Signature: _____ Date: _____

Please ensure that all the requested documents are attached, as your application will not be considered without them.

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