

NBB REGISTRATION NO.

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لجباڤا جور وراوت باڤي بروني
NURSING BOARD FOR BRUNEI

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How to complete this application form

- Read and **complete all questions.**
- Ensure that **all pages** and required **attachments** are returned to **NBB** or **BMO.**
- Use a **blue** pen only.
- Print clearly in **BLOCK LETTERS.**
- Place X in **all** applicable boxes:

Privacy and Confidentiality

The **Nursing Board for Brunei (NBB)** and **Boards Management Office (BMO)** are committed to protecting personal information as private and confidential.

SECTION A: Personal details

Title: MR MRS MISS MS DR Others:

Full name:

Date of Birth: - - Country of Birth:

Age: year Gender: Male Female Nationality:

Brunei I/C No: - Colour: Yellow Purple Green

Passport No: Country of Issue:

Marital Status: Single Married Divorced Widowed

Race: Religion:

SECTION B: Contact information

What are your contact details?

Provide your current contact details below and place an next to your preferred contact phone number

Mobile	<input type="text"/>	<input type="checkbox"/>	Office	<input type="text"/>	<input type="checkbox"/>
Home	<input type="text"/>	<input type="checkbox"/>	Others	<input type="text"/>	<input type="checkbox"/>
Email	<input type="text"/>				

What is your residential address?

Residential address cannot be a PO Box.

<input type="text"/>
<input type="text"/>
<input type="text"/>

Post Code

What is your mailing address?

If different from residential address

<input type="text"/>
<input type="text"/>
<input type="text"/>

Post Code

What is your current place of practice?

The address at which you predominantly practice the profession and it **cannot** be a PO Box.

Type of Practice:

Government
 Private

Organisation /Institution :
 Hospital :
 Department :
 Area of Practice :

Telephone
 Facsimile
 Date of Commencement of Current Practice (If applicable) - -

SECTION C: Qualification for the profession

What are the details of your LATEST qualifications and examinations/ assessments? (If Any)

Nursing/Midwifery qualification and examination/assessments (Cert./Dip./First Degree, etc.)

Documents included:
 Yes
 No

Title of qualification
 Name of institution (University/College/Examining body)
 Country
 Commencement Date - -
 Completion Date - -

SECTION D: Declaration and Signature of Applicant

1	Have you ever been or are you currently the subject of an inquiry or an investigation by any licensing authority in Brunei Darussalam or other countries with regards to professional misconduct, clinical malpractice or negligence claim?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2	Have you ever suffered or are you suffering from any physical or mental illness which impairs your fitness to practise as a Registered Nurse / Assistant Nurse?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3	Have you ever been convicted in Brunei Darussalam or elsewhere of any offence?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

- ✓ I hereby declare that to the best of my knowledge and belief the information provided above and the attached documents are true and authentic.
- ✓ I acknowledge that the Nursing Board for Brunei (NBB) reserves all rights to withhold and/or terminate my registration and/or take any action it deems fit if any of the above information or documents tendered is found subsequently to be false.
- ✓ I am also aware that it is a **criminal offence** to make any false statements, to provide any false information and or document(s) to NBB under Section 9 of Nurses Registration Act, Cap 140, **punishable** with a fine of BND 6,000.00 and imprisonment for twelve (12) months.
- ✓ I hereby also authorize the NBB and Boards Management Office (BMO) to release any information and/or relevant documentation provided by me to the other parties for the purposes of their official duties under current legislations.

Signature of applicant: Date: - -

SECTION E: FOR OFFICE USE ONLY

Payment for renewal of Practising Certificate
 Amount **B\$25.00** Receipt No.: Date: - -

Fee for late renewal of Practising Certificate
 Amount Receipt No.: Date: - -

Overdue by: days **Renewal approved** **Renewal rejected:**

Comments:
 Received by:
 Signature Date: - -



**CONTINUING PROFESSIONAL
DEVELOPMENT (CPD)
LOG RECORD**

Qualifying Period	
Start Date	
End Date	

Name			
Registration No.		Type of Registration	

Please provide information for each learning activity until the required minimum CPD points is achieved.

Dates	Topic(s) / Title(s)	Organiser(s)	Type	No. of Hours	CPD Points
Overall Total of CPD Points					

**Please add a separate copy as necessary.*

NOTE:
 Topic/Title : Name of the session or particular topic / title etc.
 Type : Attendee / Speaker / online learning etc.
 CPD Points : 1 hour session is equivalent to 1 CPD point, some activities may also be in point-based system.

To be verified by the Head of the Unit or its equivalent.

Name :

Job Title :

Contact Number :

Email :

CRITERIA:

CPD Points Achieved YES

 NO If NO, please specify reason:

Satisfactory Individual Performance YES Grade: _____

Appraisal or others: NO If NO, please specify reason:

Please specify type for others:

Declaration

I confirm that _____
has demonstrated that he/she has complied with all of NBB practising certificate / license renewal requirements as per Standard of Registration.

I agree to be contacted by NBB to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse's renewal application at risk.

<i>Signature</i>
<i>Date</i>

<i>Official Stamp</i>
