SINGAPORE NURSING BOARD

APPLICATION FOR REGISTRATION/ ENROLMENT

REGISTRATION DETAILS

Recent Passport-sized Photograph	

1. *TYPE OF REGISTER /ROLL
   ☐ Registered Nurse ☐ Registered Nurse (Psychiatric)
   ☐ Registered Midwife ☐ Enrolled Nurse

2. *TYPE OF APPLICATION
   ☐ New Application for Registration/Enrolment
   ☐ Temporary Registration (HMDP /CAIEP /Nursing Studies /Clinical Practice /Teaching /Research /Voluntary / Others (Specify) _____

3. I am also trained in other healthcare profession: _____

PARTICULARS OF APPLICANT

4. *IDENTIFICATION TYPE:
   ☐ NRIC ☐ FIN ☐ Passport

5. *IDENTIFICATION NO.:

6. *SALUTATION:
   ☐ Prof ☐ Assistant Prof ☐ Dr
   ☐ Sir ☐ Mr ☐ Ms
   ☐ Miss ☐ Mdm

7. *FULL NAME AS SHOWN IN NRIC/PASSPORT (Please underline surname):

8. NAME IN CHINESE CHARACTERS:
   (For Chinese applicant only)

9. *GENDER:
   ☐ Male ☐ Female

10.	RACE: ☐ Chinese ☐ Eurasian ☐ Indian ☐ Malay ☐ Others (Specify):_____
11.	*DATE OF BIRTH: Day Month Year
12.	*NATIONALITY: ☐ Singaporean ☐ Others (Specify):_____
13.	*COUNTRY/PLACE OF BIRTH: ☐ Singapore ☐ Others (Specify):_____
14.	*MARITAL STATUS: ☐ Single ☐ Married ☐ Cohabitated ☐ Separated ☐ Divorced ☐ Widowed
15.	RELIGION: ☐ Buddhism ☐ Christianity ☐ Free Thinker ☐ Hinduism ☐ Islam ☐ Sikhism ☐ Others:_____
16.	YEAR OBTAINED CITIZENSHIP (if converted from other nationalities): _____
17.	OTHER NATIONALITY: _____
18.	*RESIDENTIAL STATUS (if not Singapore citizen): ☐ Singapore Permanent Resident ☐ Employment Pass ☐ Work Permit ☐ S Pass ☐ Dependent's Pass ☐ Others (Specify): _____
	YEAR PR OBTAINED (if available): _____
	YEAR EP OBTAINED (if available): _____
	YEAR WP OBTAINED (if available): _____
19.	*PREFERRED EMAIL ADDRESS: _____
20.	ALTERNATE EMAIL ADDRESS: _____
21.	HOME TEL NO.: +65 _____
22.	OFFICE TEL NO.: +65 _____
23.	MOBILE NO.: +65 _____
24.	*RESIDENTIAL ADDRESS IN SINGAPORE House / Block Number Level Unit Street Name Building Name Postal Code

25. OTHER SINGAPORE RESIDENTIAL ADDRESS

House / Block Number | Level | Unit

Street Name

Building Name

Postal Code

26. FOREIGN ADDRESS

Country

Address Line 1

Address Line 2

Address Line 3

Address Line 4

Contact No.

27. *PREFERRED MAILING ADDRESS

☐ Residential Address in Singapore ☐ Other Singapore Residential Address

☐ Foreign Address

28. INFORMATION ON SPOUSE

a. FULL NAME AS SHOWN IN NRIC/PASSPORT (Please underline surname):

b. NATIONALITY: _____

c. OCCUPATION: _____

d. If spouse is working in Singapore

Company Name

House / Block Number | Level | Unit

Street Name

Building Name

Postal Code

e.	If spouse is a registered healthcare professional in Singapore SINGAPORE HEALTHCARE PROFESSIONAL ENTITIES ☐ Singapore Medical Council ☐ Singapore Dental Council ☐ Singapore Pharmacy Council ☐ Singapore Nursing Board ☐ Traditional Chinese Medicine Practitioners Board ☐ Optometrists and Opticians Board ☐ Allied Health Practitioners Board REGISTRATION NO.: _____
f.	If Spouse is not a registered healthcare professional in Singapore, does your spouse intend to apply for registration in Singapore? ☐ Yes ☐ No If yes, please provide details _____ _____

QUALIFICATIONS AND CLINICAL / PRACTICE EXPERIENCE OF APPLICANT

29.	**BASIC NURSING /MIDWIFERY QUALIFICATION OBTAINED**
a.	*COUNTRY: _____
b.	*UNIVERSITY / INSTITUTION: _____
c.	*QUALIFICATION TYPE: ☐ Masters Degree ☐ Bachelor's Degree ☐ Graduate Diploma ☐ Diploma ☐ Others, pls specify: _____
d.	*QUALIFICATION NAME: _____
e.	ABBREVIATION OF QUALIFICATION: _____
f.	SUBJECT AREA / SPECIALTY: _____
g.	*PROGRAMME TYPE: ☐Full-time ☐ Part-time
h.	*COURSE DURATION: _____ months
i.	*START DATE (dd/mm/yyyy): _____
j.	*END DATE (dd/mm/yyyy): _____
k.	*YEAR OBTAINED (yyyy): _____
l.	*TWINNING PROGRAMME: ☐ Yes ☐ No If "Yes", please specify Twinning Partner: _____
m.	Please complete the following section only if you DID NOT complete your basic qualification in the SAME University / Institution / Country.

Year	Country	University / Institution	Start Date (dd/mm/yyyy)	End Date (dd/mm/yyyy)
1				
2				
3				
4				
5				

n.

Please specify the details for gap periods of more than 1 year

Period (dd/mm/yyyy) to (dd/mm/yyyy)	Details

30. *Are you required to take a licensing examination before you can practice as a Nurse/ Midwife in the country where you obtained your primary professional qualification?

☐ Yes ☐ No

If "Yes", please provide details

_____

_____

31. If licensing examination is required, have you attempted and passed the required examination?

☐ Yes ☐ No

If "No", please provide details

_____

_____

32. POSTGRADUATE / POST-REGISTRATION NURSING /MIDWIFERY QUALIFICATIONS OBTAINED

Country	University / Institution	Full Name of Qualification	Abbreviation of Qualification	Programme Type	Specialty	Year Conferred (yyyy)
				☐ Full-time ☐ Part-time		
				☐ Full-time ☐ Part-time		
				☐ Full-time ☐ Part-time		
				☐ Full-time ☐ Part-time		
				☐ Full-time ☐ Part-time		

33. CLINICAL / HOUSEMANSHIP / INTERNSHIP EXPERIENCE OF APPLICANT

Country	University / Institution	Department	Discipline	Start Date (dd/mm/yyyy)	End Date (dd/mm/yyyy)	Total Clinical Practice Hours

34. *WORK PRACTICE EXPERIENCE (AS A NURSE/ MIDWIFE) **For foreign trained applicants only**

Date Joined (dd/mm/yyyy)	**Date Left** (dd/mm/yyyy)	**Country**	**Name of Institution / Organisation**	**Department**	**Grade / Designation / Appointment**	**Type**
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________
						☐ Full-time ☐ Part-time, no of hrs per week: ___________

35. Please provide details for gap periods of more than 1 year or more in your work practice experience, if any.

Period (dd/mm/yyyy) to (dd/mm/yyyy)	Details

36. *NURSING / MIDWIFERY REGISTRATION / LICENSING DETAILS (obtained outside Singapore) **For foreign trained applicants**

Country	**Council / Registration Authority**	**Registration Type / Category**	**Registration / Licensing No.**	**Registration Date**	**Current PC No.**	**Current PC Start Date** (dd/mm/yyyy)	**Current PC End Date** (dd/mm/yyyy)

(in reverse chronological order)

EMPLOYMENT DETAILS OF APPLICANT

37. CURRENT (SINGAPORE) EMPLOYMENT DETAILS

a. *ACTIVITY STATUS:
☐ Working full-time ☐ Working part-time ☐ Not Working
If "Not Working", please state the reason:
_____
_____

If "Working part-time", please state the number of hours per week: _____

b. APPOINTMENT: _____

c. NAME OF INSTITUTION / ORGANISATION: _____

d. NATURE OF WORK:
☐ Clinical ☐ Teaching / Research ☐ Others, specify: _____

e. DEPARTMENT / DIVISION: _____

f. DATE JOINED (dd/mm/yyyy): _____

g. DATE LEFT (dd/mm/yyyy): _____

38. PROPOSED (SINGAPORE) EMPLOYMENT DETAILS

a. *APPOINTMENT: _____

b. *NAME OF INSTITUTION / ORGANISATION: _____

c. NATURE OF WORK:
☐ Clinical ☐ Teaching / Research ☐ Others, specify: _____

d. DEPARTMENT / DIVISION: _____

e. DATE JOINED (dd/mm/yyyy): _____

39. PRINCIPAL PLACE OF PRACTICE

a. *APPOINTMENT: _____

b. *NAME OF INSTITUTION / ORGANISATION: _____

c. NATURE OF WORK:
☐ Clinical ☐ Teaching / Research ☐ Others, specify: _____

d. DEPARTMENT / DIVISION: _____

e. DATE JOINED (dd/mm/yyyy): _____

f. DATE LEFT (dd/mm/yyyy): _____

40. SECONDARY PLACE(S) OF PRACTICE

Appointment	Institution / Organisation	Nature of Work	Department / Division	Date Joined (dd/mm/yyyy)	Date Left (dd/mm/yyyy)
		☐ Clinical ☐ Teaching / Research ☐ Others, specify: _____			
		☐ Clinical ☐ Teaching / Research ☐ Others, specify: _____			

DECLARATIONS

41. *Have you ever been:

a) convicted by any court of law whether in Singapore or elsewhere, of any offences?

☐ Yes ☐ No

If "Yes", please provide full details

_____

_____

b) the subject of adverse finding(s) in proceedings before any professional body or tribunal whether in Singapore or elsewhere*?

☐ Yes ☐ No

If "Yes", please provide full details

_____

_____

42. *Are you currently or have you ever been the subject of any proceedings, inquiry or investigation, by any authority/institution (including educational institution*), professional or regulatory body, licensing or health authority, the police, or any other law enforcement agency, in Singapore or elsewhere, the subject matter of which may give rise to concerns relating to professional misconduct, your professionalism and/or your behaviour which may affect your suitability and fitness to practise in the profession?

**examples of concerns that could arise during your education include cheating, plagiarism, theft, falsifying documents, reports or records, assault, harassment and drug or sexual offences*

☐ Yes ☐ No

If "Yes", please provide full details

_____

_____

_____

43. *Are you currently or have you ever been the subject of an inquiry or proceedings by a professional body, Health Authority or court of law in Singapore or elsewhere, involving or relating to any physical or mental illness suffered by you?

☐ Yes ☐ No

If "Yes", please provide full details

_____

_____

_____

44. *Do you have an ongoing health condition (including physical, mental or other health conditions)* which may impair your fitness to practise as a registered healthcare professional? (Please read the important notes before proceeding)

Note: Healthcare practitioners do not need to declare inactive or resolved health conditions which do not require further care and follow-up with a registered medical practitioner.

☐ Yes ☐ No

If "Yes", please provide full details

_____

_____

_____

SNB may contact you for clarification and request that you submit a medical report from your attending physician about your current health condition pertaining to fitness to practise.

*Applicant's Name (as per passport/ NRIC): _____

*Applicant's Signature & date: _____

	* Important Notes for Declaring Health Conditions: *'Physical health conditions'* includes (a) chronic medical illnesses or dermatological conditions which if associated with an exacerbation or with organ dysfunction complications, may hinder the healthcare practitioner's ability to provide appropriate and safe clinical care, as well as (b) health conditions or its sequelae which restrict the healthcare practitioner's subsequent ability to engage in safe clinical practice within the specific work setting that the healthcare practitioner is in. *'Mental health conditions'* refers to a range of conditions which are diagnosed and treated by a registered psychiatrist, and which may affect the decision making ability of the healthcare professional and compromise the well-being and safety of his patients/clients. These could include anxiety disorders, mood disorders (depressive and bipolar disorders) and psychotic disorders (such as schizophrenia) as well as addictions. *'Other health conditions'* refers to other conditions which may compromise the ability of the healthcare professional to assess relevant information in order to come to a diagnosis of his patient/client's clinical condition and/or formulate a management plan for his patient/client. This may include miscellaneous conditions for example dyslexia and other learning disorders, colour blindness or other conditions compromising the function of the healthcare professional's visual and auditory senses.
45.	*Have you ever applied for registration with SNB? ☐ Yes ☐ No If "Yes", please provide full details _____ _____ _____
46.	*If you are performing Exposure Prone Procedures (EPP), it is MOH's policy that you should know your BBD status due to the risk of transmission during such procedures. All healthcare workers who have been diagnosed with BBD should declare their status to their respective Professional Boards/ Councils. Healthcare workers with BBD should not perform EPP. a) Are you practising any exposure prone procedures (Exposure Prone Procedures (EPP))? ☐ Yes ☐ No b) Are you aware that you are a carrier of any blood-borne diseases (BBD) such as Hep B, Hep C or HIV? ☐ Yes ☐ No Your current BBD Declaration is different with your past declarations, please provide the reason below. **(To indicate NA if not applicable)** _____ _____ _____ **If you answered "Yes" to Question 46 (b), please complete the following Undertaking:** ☐ I declare that I am a carrier of a blood borne disease and hereby acknowledge that I will not perform any exposure-prone procedure in view of my infected status and the possible risk of transmission to my patients. I will also comply with all applicable guidelines pertaining to blood-borne diseases as may be issued by the Ministry of Health[1] and/or other regulatory agencies as well as ensure that I am not placed in any situation where there may be a possible risk of transmission to my patients. ☐ I understand and agree that failing to adhere to the above may result in the cancellation of my registration (on any or all registers) and practising certificate/s with the Singapore Nursing Board. [1]Please refer to "MOH DIRECTIVE ON MANAGEMENT OF HEALTHCARE WORKERS (MEDICAL, DENTAL, NURSING AND PARAMEDIC) WITH HEPATITIS B, HEPATITIS C AND HIV"

*Applicant's Name (as per passport/ NRIC): _____

*Applicant's Signature & date: _____

47.	☐ *I declare that the particulars stated in this application and the documents attached are true, correct and complete and the information contained herein remains true, correct and complete to date. I undertake to inform SNB of any data discrepancy (e.g. inaccurate/outdated data) and I am aware that I may be asked to provide more information to the SNB, if necessary. To the best of my knowledge and belief, I have not withheld any material fact. ☐ *I acknowledge that the SNB reserves all rights to withhold registration or to remove my name from the appropriate register and/or take any action it deems fit, if any of the above information or documents tendered are subsequently found to be false. I am aware that I may be liable to be prosecuted under section 30(a) of the Nurses and Midwives Act (NMA) for knowingly making any false or fraudulent declaration or representation, whether in writing or otherwise to the SNB. I also understand and give my consent for the SNB to make any enquiries or to obtain any information & documents which it may require to verify my qualifications and fitness to practise. ☐ *I acknowledge that the SNB reserves all rights to receive, collect and/or transmit the above personal data to other authorities or agencies if required to do so for the purpose of carrying out its duties under the Nurses and Midwives Act (NMA) and/or for compliance with any other Acts and subsidiary legislations. I also acknowledge that SNB is not liable for any damage or loss caused to me in the course of my using the Professional Registration System (PRS) due to data errors in the personal data I provide. The personal data collected will be kept in the strictest confidence and access restricted only to authorised persons. To safeguard all personal data, all electronic storage and transmission of personal data are secured through appropriate security technology. ☐ *I agree to allow this application including all of the information contained, and declarations set out, in this application to be accessed by prospective employer.

*I agree for my employing hospital/ institution

_____ (to indicate applicant's place of practice) to submit my application for registration/enrolment and all my supporting documents on my behalf (if applicable).

_____

Signature & Date of Applicant

Name of Applicant *(As per passport/ NRIC)* : _____

NRIC / FIN/ Passport Number : _____

Date of Birth (DD/MM/YYYY) : _____

*I, _____, (indicate HR Rep's name) declare that I:

a) have sighted all original copies of documents provided by the applicant;
b) will submit copies of documents provided by the applicant in (a) above for application for registration/ enrolment with SNB.

_____

Signature & Date of Employer HR Rep

Name of Employer HR Rep *(As per passport/ NRIC)* : _____

NRIC/ FIN (last 3 digits and alphabet) **OR** Employer HR/ Nursing Rep's Employee number : _____

Designation : _____