NURSES COUNCIL OF ZIMBABWE

16 Dale Road
Marlborough
Harare
Telephone: 0242-300169, 0242- 309436
Email: registrar@nursescouncil.co.zw

P O Box A830
Avondale
Harare

APPLICATION FOR RE-REGISTRATION /RESTORATION

THIS FORM MUST BE SUBMITTED WITH THE FOLLOWING DOCUMENTS:

a) **Typed application letter (signed by applicant) addressed to the Registrar of Nurses Council of Zimbabwe**
b) **Certified copies of diplomas/degree and registration certificates for all qualifications registered with Nurses Council of Zimbabwe**
c) **Proof of your last renewal or your last Practising Certificate**
d) **Two recent passport size photographs (with name, signature and ID number written at the back)**
e) **Comprehensive curriculum vitae**
f) **Proof of payment of the prescribed non-refundable re – registration/restoration fee**
g) **CPD points for renewal of current Practising Certificate**

NB: If practising out of Zimbabwe:

i) **Certificate of Good Standing from the regulatory board (Nurses Council) of the country, sent directly to Nurses Council of Zimbabwe from the Registering Board.**
ii) **Two testimonials /references from professional nurses you have been working with in the last six months.**
iii) **Certified copy of current/Valid Practising Certificate.**

Note: 1. Council does not accept inadequate and incomplete documents
2. The application lapses after 6 months (if council requests for additional information and the applicant does not provide it) therefore the applicant has to reapply after this period
3. Turnaround time is 3 months

(Complete in block letters)

I hereby apply for re- registration as a_____

Registration Number: _____

1. PARTICULARS OF APPLICANT

TITLE: ☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR

☐ MALE ☐ FEMALE

SURNAME _____

FIRST NAMES _____

PREVIOUS NAMES (Where applicable) _____

DATE OF BIRTH | | | | | | | | |

PLACE OF BIRTH: TOWN _____ COUNTRY _____

NATIONALITY _____ **I.D. NUMBER** _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ OTHER (STATE)

RESIDENTIAL ADDRESS:

_____

_____

POSTAL ADDRESS:

_____

_____

TELEPHONE NUMBER: HOME_____ WORK _____ CELL _____

EMAIL ADDRESS: _____

2. PROFESSIONAL QUALIFICATIONS ALREADY REGISTERED WITH NURSES COUNCIL OF ZIMBABWE

QUALIFICATIONS	NAME OF TRAINING INSTITUTION	DURATION		AWARDED BY	DATE AWARDED
		FROM	TO		

3. PROFESSIONAL QUALIFICATIONS NOT REGISTERED WITH NURSES COUNCIL OF ZIMBABWE (IF ANY)

QUALIFICATIONS	NAME OF TRAINING INSTITUTION	DURATION		AWARDED BY	DATE AWARDED
		FROM	TO		

4. DETAILS OF EMPLOYMENT SINCE QUALIFYING

NAME AND ADDRESS OF EMPLOYER	POSITION HELD	PERIOD	
		FROM	TO

DATE _____ SIGNATURE_____

FOR OFFICIAL USE ONLY

RECEIVED (amount) _____ RECEIPT NUMBER _____

APPROVED: ☐ YES ☐ NO

IF YES: DATE OF REGISTRATION _____

CONDITIONS: _____

IF NO: REASON _____

DATE _____ SIGNATURE_____

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NURSES COUNCIL OF ZIMBABWE

APPLICATION FOR PRACTISING CERTIFICATE

(Complete in Block Letters)

I hereby apply for practicing certificate to practice as a_____ (state profession)

REGISTRATION NUMBER | | | | | | | | | | |

SURNAME _____

FIRST NAMES _____

REGISTRATION ADDRESS/POSTAL ADDRESS_____

_____

Please advise any change in your registration particulars with authenticated documents where appropriate

1. **DETAILS OF LAST EMPLOYMENT**

   EMPLOYER_____

   DATES OF EMPLOYMENT FROM _____TO_____

2. **DETAILS OF EMPLOYMENT IN ZIMBABWE**

   EMPLOYED YES ☐ NO ☐

   NAME OF PLACE OF PROPOSED EMPLOYEMENT IN ZIMBABWE_____

   PHYSICAL ADDRESS_____

   _____

   POSTAL ADDRESS_____

   EMAIL ADDRESS_____

   TELEPHONE NUMBER HOME_____WORK_____CELL_____

TICK AS APPROPRIATE

3. **AREA OF EMPLOYMENT**

   ☐ GOVERNMENT ☐ MISSION ☐ LOCAL AUTHORITY ☐ PRIVATE

OTHER (PLEASE SPECIFY) _____

4. EMPLOYMENT STATUS

☐ FULL TIME ☐ PART TIME ☐ TEMPORARY

5. TYPE OF INSTITUTION

☐ HOSPITAL ☐ CLINIC ☐ EDUCATION INSTITUTION

☐ NURSING HOME ☐ AGENCY ☐ MINE

OTHERS (SPECIFY) _____

6. PROVINCE EMPLOYED

☐ BULAWAYO ☐ HARARE ☐ MANICALAND

☐ MASHONALAND CENTRAL ☐ MASHONALAND WEST ☐ MASHONALAND EAST

☐ MASVINGO ☐ MATEBELELAND NORTH ☐ MATEBELELAND SOUTH

☐ MIDLANDS

7. IF NOT EMPLOYED REASON

☐ POSITION NOT AVAILABLE ☐ FAMILY REASON

☐ TO GO ABROAD ☐ UNDERTAKING FURTHER STUDIES

☐ RETIRED OTHER (Specify) _____

NOTE: 1. IT IS AN OFFENCE TO PRACTISE IF NOT IN POSSESSION OF A VALID PRACTISING CERTIFICATE, AND TO PRACTISE IN A REGISTERED HEALTH INSTITUTION

2. PERSONS WHO DO NOT REMAIN IN CONTINUOUS PRACTICE MAY BE REQUIRED ON WISHING TO RESUME THEIR PRACTISE TO WORK IN A SPECIFIED SITUATION FOR A SPECIFIED PERIOD

DATE _____ SIGNATURE_____

_____

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APPROVED: ☐ YES ☐ NO

CONDITIONS IF ANY: _____