

**The Nursing Council of Hong Kong**  
**Application for Limited Registration/Enrolment (Psychiatric)**  
**under the Nurses Registration Ordinance, Cap. 164**  
**(for nurses trained outside Hong Kong)**

**VERIFICATION OF ORIGINAL REGISTRATION/ENROLMENT OUTSIDE HONG KONG**

To: The Secretary, Nursing Council of Hong Kong  
 1/F, Shun Feng International Centre  
 182 Queen's Road East  
 Wanchai, Hong Kong  
 Email: nc@dh.gov.hk

***INSTRUCTIONS TO APPLICANT***

Please send this document to the Registration Authority which issued your Original Registration/Enrolment Certificate (outside Hong Kong) for completion. You may be required to pay a fee to the Authority for the service you request.

**TO BE COMPLETED BY AN OFFICER OF THE REGISTRATION AUTHORITY (in BLOCK letters)**

Please confirm the registration/enrolment details of the nurse who has sent you this form by filling in the space provided. After completion, please stamp the official seal of your Registration Authority in the space provided below and send this form to the Nursing Council of Hong Kong **direct** at the address given above in an official and sealed envelope of your Registration Authority or by email via its official email account. Otherwise, the form will be regarded as invalid.

Name of nurse: (Surname) \_\_\_\_\_ (Given name) \_\_\_\_\_

Date of birth (DD/MM/YY): \_\_\_\_\_ Gender: Male/Female^

Name of Registration Authority: \_\_\_\_\_

Address of Registration Authority: \_\_\_\_\_

Registration/Enrolment^ no.: \_\_\_\_\_

Date of initial registration/enrolment^: \_\_\_\_\_  
 (DD/MM/YY)

Expiry date of the practising certificate: \_\_\_\_\_  
 (DD/MM/YY)

Part under which the registration/enrolment^ was granted (if applicable): \_\_\_\_\_

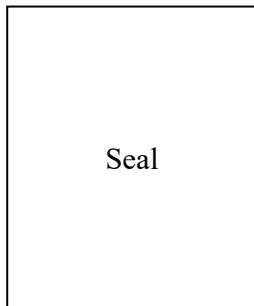
I confirm that the registration/enrolment^ of the above-named applicant **\*is/is not^** currently valid.

If the applicant's registration/enrolment^ is not currently valid, please state the reason(s): \_\_\_\_\_

^ Please delete as appropriate.

Please provide the following information concerning the registration/enrolment status of the above-named applicant -

	If <b>YES</b> is selected for any of the questions below, please attach an explanation for each.	<b>YES</b>	<b>NO</b>
1.	Has the applicant ever been refused to registration/enrolment^ to practise as a nurse in your or any other jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has the applicant's registration/enrolment^ ever been revoked, suspended, surrendered, restricted or subject to individual terms and conditions?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is there any current conditions or limitations or restrictions in regard of the applicant's registration/enrolment^?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has the applicant been found guilty of unprofessional conduct in your or any other jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is there any disciplinary proceedings in progress against the applicant in relation to the practice of nursing?	<input type="checkbox"/>	<input type="checkbox"/>
6.	To the best of your knowledge, is the applicant currently subject to criminal proceedings or has been convicted of any offence punishable with imprisonment in your or any other jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>



Signature: \_\_\_\_\_

Full name: \_\_\_\_\_  
*(in block letters)*

Capacity in  
Registration Authority: \_\_\_\_\_

Date (DD/MM/YY): \_\_\_\_\_

Please stamp official seal of Registration Authority in the space provided.