



THE ASSOCIATION OF  
**REGISTERED NURSES**  
OF PRINCE EDWARD ISLAND

Unit 6 - 161 Maypoint Rd, Charlottetown PE C1E 1X6  
Tel: 902-368-3764 Fax: 902-628-1430 Email: info@arnpei.ca

**Instructions for Applying for Registration for  
New Graduates of Canadian Nursing Education Programs outside of PEI**

1. Complete the *Application for Registration in Prince Edward Island* and return to ARNPEI at the above address with the non-refundable processing fee of \$40 in Canadian funds and proof of legal name (copy of birth certificate; copy of change of name certificates e.g. marriage/divorce).
2. Submit a current criminal record check through CSI Screening. Log on to [www.csiscreening.com](http://www.csiscreening.com), complete the Canadian Criminal Record Check and indicate “ARNPEI – Association of Registered Nurses of PEI” as the company. Criminal record checks are valid for six months from the date of issue. A vulnerable sector check is required.
3. Complete Section A of the *Confirmation of Program Completion for Graduates of Canadian Nursing Education Programs Outside of PEI* and forward to the Dean/Director of your nursing education program. Request the Dean/Director to complete Section B and forward to ARNPEI.
4. Upon receipt of the above, we will notify as to your eligibility for the National Council Licensure Examination for Registered Nurses (NCLEX-RN). If you have passed the NCLEX-RN in another jurisdiction, request the registering/licensing authority to forward your result to ARNPEI.



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**Application for Registration**

**To be completed by the applicant and returned to the Association of Registered Nurses of PEI.**

Name \_\_\_\_\_  
Surname Given Names Birth/Former Name(s)

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_ Gender  Female  Male  
Month/Day/Year

School of Nursing & Location \_\_\_\_\_

Course Started: \_\_\_\_\_ Course Completed: \_\_\_\_\_  
Month/Year Month/Year

I am requesting a permit to practice as a Graduate Nurse in Prince Edward Island. Yes \_\_\_ No \_\_\_

Are you proficient in English? Yes \_\_\_ No \_\_\_

I declare the above statements to be true:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



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**Confirmation of Program Completion for  
Graduates of Canadian Nursing Education Programs outside PEI**

**Section A** - Complete Section A and forward to the Dean/Director of your nursing education program.

Name \_\_\_\_\_  
Surname Given Names Birth/Former Names(s)

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Month/Day/Year

School of Nursing & Location \_\_\_\_\_

Course Started: \_\_\_\_\_ Course Completed: \_\_\_\_\_  
Month/Year Month/Year

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section B** - To be completed by the Dean/Director and forwarded to the Association of Registered Nurses of PEI.

I certify that the above named applicant has completed the nursing education program indicated above on:

\_\_\_\_\_  
Completion date of program

I confirm that this entry-level nursing education program is accepted by \_\_\_\_\_ (name of regulatory body) and that the name of the education program is recorded correctly above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dean/Director



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**VISA/Mastercard Payment Authorization Form**

Name as it appears on credit card

Name as it appears on application if different than the name on the credit card

Phone number where the card holder can be reached

Email address

Please indicate which fee you are paying for

Please bill my

- VISA**  
 **MASTERCARD**

in the amount of \$ \_\_\_\_\_

Card Number \_\_\_\_\_

Expiry Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please note:** The credit card information provided on this form will not be retained. Upon authorization of the payment request all credit card information will be destroyed.