



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  
Applicants Previously Registered in Canada**

The following steps/procedures must be followed when applying for registration with the Association of Registered Nurses of Prince Edward Island (ARNPEI).

**PART I** - Complete and return to ARNPEI with

- the non-refundable application fee of \$40 in Canadian funds
- copy of birth certificate
- copy of change of name certificates eg. marriage/divorce certificates
- copy of government-issued identification with your photo on it (such as a photocopy of your passport photo page or driver's license).

**PART II** - Forward to the nurse registering authority where you were originally registered, i.e. upon completion of your nursing education program, and request them to complete and return it directly to ARNPEI.

**PART III** - Forward to the nurse registering body where you are currently registered (if different from Part II) and request them to complete and return it directly to ARNPEI.

**PART IV** - Forward to your last employing agency(s) and request them to complete and return it directly to ARNPEI. You must have worked a minimum of 1125 hours of paid nursing employment within the previous five years or have graduated within the previous five years.

**PART V** - Submit a criminal record check that includes a vulnerable sector check. The criminal record check must have been issued within one month prior to the date of submission. If you have resided outside of Canada within the previous two years an international criminal check is also required.

Upon receipt of the above, we will notify you as to your eligibility for registration.



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**Application for Registration**

**Part I - 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

Nursing Experience Since Graduation: (List three most recent employers)

Name and Address of Employer	Position	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any conditions placed on your registration or had your license suspended, cancelled, revoked or terminated for reasons of incompetence or misconduct?  Yes  No

Have you ever been disciplined by an employer or a registration or licensing authority?  Yes  No

Are you proficient in English?  Yes  No

**By signing this application form:**

I authorize ARNPEI to carry out the procedures necessary for the assessment of my eligibility for registration. This includes making copies of my application documents for the purpose of assessment and/or contacting the institutions or authorities stated on this application to verify the authenticity of my documents and the information provided regarding the educational institutions, regulatory bodies, and employers listed in my application.

I declare that all of the information I have provided on this form is complete and truthful.

I understand that ARNPEI will immediately:

1. stop the assessment of my application and
2. that my application for assessment will be cancelled, registration will be refused, and I will be banned from applying to the ARNPEI in the future if:
  - a. I have provided any inaccurate information or
  - b. I have omitted required information; or
  - c. the ARNPEI determines that any documents submitted during the application or assessment process have been altered, tampered with or forged.

This applies to all documents received during the application process, including verifications of registration and written correspondence. ARNPEI will not issue a refund and will retain all documents submitted with my application.

I understand that in order to practice nursing in Prince Edward Island, I am required by law to hold a license with ARNPEI before I commence employment, including any orientation.

I understand that the Registrar may destroy the application and supporting documentation of an applicant if the applicant has not completed the application within two years of the date the applicant submitted to the Registrar the completed application form.

I have read and understand the above and the information on this form and agree to the terms stated herein.

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Signature of Applicant

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Date



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### Application for Registration

#### Part II - Verification of Original Nurse Registration and Examination Scores

**Section A** - Complete Section A and forward to the registering/licensing authority who issued your **ORIGINAL** registration/licensure. Request they verify your status by completing Section B.

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

Address \_\_\_\_\_

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

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

Year of Graduation \_\_\_\_\_ Year registered in original jurisdiction \_\_\_\_\_ Registration Number \_\_\_\_\_

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

**Section B** - To be completed by the registering/licensing authority issuing **ORIGINAL** registration/licensure and returned directly to the Association of Registered Nurses of Prince Edward Island.

Acting on behalf of the \_\_\_\_\_  
Name of Original Registering Authority

I do hereby certify that \_\_\_\_\_  
Surname Given Names Birth/Former Names

is a graduate of \_\_\_\_\_  
School of Nursing Location Type of Program

and that the nursing education program was an approved program at the time of completion. The original registration certificate/license as a general registered nurse was issued by this jurisdiction on \_\_\_\_\_

Registration number \_\_\_\_\_ Registration was obtained by examination \_\_\_\_\_ endorsement \_\_\_\_\_

Registration status \_\_\_\_\_ Expiry date of registration \_\_\_\_\_

Is/has this registration/license ever been suspended, had conditions imposed, revoked or under investigation? (If yes, please attach an explanation.) YES/NO \_\_\_\_\_ If yes, has this registration/license been reinstated? YES/NO \_\_\_\_\_

Examination written \_\_\_\_\_ Number of writings \_\_\_\_\_

Date Exam Passed \_\_\_\_\_ Passing score \_\_\_\_\_

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



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#### Part III - Verification of Current Nurse Registration

**Section A** - Complete Section A and forward to the registering/licensing authority who issued your **CURRENT** registration/licensure. Request they verify your status by completing Section B.

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

Address \_\_\_\_\_

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

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

Year of Graduation \_\_\_\_\_ Year registered in your jurisdiction \_\_\_\_\_ Registration Number \_\_\_\_\_

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

**Section B** - To be completed by the registering/licensing authority issuing **CURRENT** registration/licensure and returned directly to the Association of Registered Nurses of Prince Edward Island.

Acting on behalf of the \_\_\_\_\_  
Name of Registering Authority

I do hereby certify that \_\_\_\_\_  
Surname Given Names Birth/Former Names

a graduate of \_\_\_\_\_  
School of Nursing Location

was issued a certificate of registration as a registered general nurse by this jurisdiction on \_\_\_\_\_  
Month/Day/Year

Registration Number \_\_\_\_\_ Registration was obtained by examination \_\_\_\_\_ endorsement \_\_\_\_\_

Registration status \_\_\_\_\_ Expiry date of registration \_\_\_\_\_

Is/has this registration/license ever been suspended, had conditions imposed, revoked or under investigation? (If yes, please attach an explanation.) YES/NO \_\_\_\_\_ If yes, has this registration/license been reinstated? YES/NO \_\_\_\_\_

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





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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.