



Applicant's No. _____

Verification of Nursing Education

Complete this section and send this verification form to the Nursing School / College where you graduated

Present Name _____

First Middle Last
Date of Birth ___/___/19___ Sex: M F Nationality _____ Passport _____

I Graduated (Date) ___/___/19___ from (Name of school) _____

My name on my certificate /diploma was: _____

I hereby request that this verification form be completed, a transcript included and mailed to the above address _____

Signature of Applicant

Applicant not to write below this line.

To be completed by the Chief Administration Officer of the School of Nursing granting the certificate / diploma :

Dear Sir/ Madam,

The above applicant has applied to practice Nursing in the United Arab Emirates. We will greatly appreciate your assistance in evaluating his / her application by completing this verification form.

Recorded Name of Graduate _____

Name of School/ College _____
Address of School/ College _____

School Approved By _____

Date Student Entered ___/___/___ Date Course Completed ___/___/___

Length of Course _____ Date of Diploma ___/___/___

Graduating average percentage of total marks _____%

Type of Certificate/ Diploma: _____

Qualification entitles graduate to practice as : _____

Please attach an official transcript (record of all subjects taken, including hours of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and signature of the Chief Administrative Officer.

Name: _____

Title: _____

Signature: _____

Date ___/___/___

School Stamp or Seal

This certification is acceptable only if submitted directly from the School / College



Reference Inquiry

Applicant is to complete this section and send or give reference inquiry to a professional supervisor who has direct knowledge of applicant's professional ability. Fill in your *Applicant's number* before you send this form.

Applicant's Name: _____

First

Middle

Last

Employed from: ___/___/___ To: ___/___/___ Job Title: _____

Clinical Assignment: _____

Applicant not to write below this line

Dear Colleague,

The above person has applied to practice Nursing/Midwifery in the United Arab Emirates, and has indicated present or past employment with your institution. Please complete this reference inquiry and be assured that this information will be held in confidence. *Do not give this reference inquiry to the applicant. Return directly to the Ministry of Health at the address indicated at the top of this form.* Thank you for your valuable assistance in this important professional matter.

- Name of Institution: _____
- Address of Institution: _____

- Date of Employment: From: ___/___/___ To: ___/___/___
 Full time Part time Number of hours worked / week: _____
- This nurse has / had the responsibilities of a:
 - Registered Nurse/1st Level Nurse /Staff Nurse Registered Midwife/1st Level Midwife
 - Practical Nurse/2nd Level Nurse /Enrolled Nurse Practical Midwife/Assistant Midwife
 - Other (please specify) _____
- Job Title: _____
- Clinical Assignment: _____

(Example: Medical / Surgical , Pediatrics, Out Patient Clinic, School Health Clinic, Dental , etc.)

Please place a tick in the box which reflects your professional judgment of the applicant *for each item*:

Item	Applicant meets Institution standards	Applicant does not meet institution standards	Not observed
•Demonstrates the ability to implement nursing Interventions / midwifery care effectively and efficiently			
•Records / reports appropriately and accurately the delivery of care / service to clients			
•Complies with policies / procedures / guidelines of institution			
•Demonstrates caring and sensitivity in professional relationships with clients, families and co-workers			
•Demonstrates honesty and integrity			
•Communicates and cooperates with co-workers in delivery of care / service to clients			
•Manages assigned duties effectively and on time			
•Communicates effectively with clients / families to provide information and /or teaching			
•Demonstrates ability to deal with conflict appropriately and effectively			
•Exercises sound judgment in assuming and / or performing delegated tasks or functions			
•Demonstrates reliability			
•Demonstrates commitment to maintaining and improving professional knowledge and skills			

Comments: _____

Official Seal

(If additional space for comments is needed; attach documentation to this form.)

Completed by: _____ Signature: _____

Position/Title: _____ Date completed: _____

Signature of Chief Nursing/ Midwifery

Medical Officer of Institution:

Position/ Title: _____ Date signed: _____

Ministry of Health
Department of Nursing
Regulation and Registration
P. O. Box 848
Abu Dhabi, United Arab Emirates



Applicant's No. _____

Verification of License/ Registration

Applicant to complete this section and mail the verification form to the Nursing/Midwifery Licensing Authority in the country where currently licensed.

I am licensed/registered by: _____
(Name of the Nursing / Midwifery Licensing Authority)

My name on the license/registration _____

My original license/registration number(s) _____

Type of License(s) _____

My name on the UAE Nursing/Midwifery Registration Application _____

Signature of applicant _____

Applicant's mailing address _____

Applicant not to write below this line. To be completed by the Licensing Authority

Dear Colleague,

The above applicant has applied to practice Nursing /Midwifery in the United Arab Emirates and has indicated licensure/ registration with your authority. Please complete and return this form directly to the address in the upper right hand corner. Please do not give this verification form to the applicant. Thank you for your valuable assistance in this important professional matter.

• Classification / type of License: _____ License No. _____
Issued On: ___/___/_____ Expiry date ___/___/_____ Or No expiry:

• Classification / type of License: _____ License No. _____
Issued On: ___/___/_____ Expiry date ___/___/_____ Or No expiry:

• Applicant Licensed by: Exam Endorsement

• Status of License(s): Current In-Active Lapsed

• Has license ever had any type of disciplinary action? (revoked, suspended, surrendered, restricted or placed on probation) No Yes (If yes, please explain and attach)

• Is licensee currently under investigation? No Yes (If yes, please explain and attach)

Name of Nursing/ Midwifery Licensing Authority: _____

Address: _____

OFFICIAL SEAL

(Name of Officer completing verification)

(Title of Officer completing verification)

(Signature)

(Date completed)