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P .0 Box 2757, Yellowknife, NT X1A 2R1

NP EXPEDITED APPLICATION -Virtual/Telehealth Services

Identification (Please print)

Full Legal Name: (include middle initial or name)		Maiden or previous Name:	
Mailing Address: (City/Town, Province/Territory, Postal Code)			
Email:			
Phone numbers: Work:		Cell or Home:	
Date of Birth:	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Other

Registration Eligibility

NOTE: If you answered "yes" for any of the eligibility questions, please attach documentation (e.g., letter of explanation, pardon). You must immediately notify the CANNN if there are any changes to the above circumstances.

Q1	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you fluent in English
Q2	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you affected by or diagnosed with a physical, mental condition/illness, disability, or drug/ alcohol addiction which may affect your ability to practice nursing?
Q3	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your registration currently, or has it ever had conditions attached, been suspended, revoked or under investigation in any jurisdiction?
Q4	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been denied registration?
Q5	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently completing, or have you ever had to complete undertakings as part of a professional conduct review with any professional regulatory body?
Q6	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been found guilty of a criminal offence in any province, territory, state or country, or do you have any outstanding charges? This includes any criminal offence for which your received a pardon.

Consent:

I declare I am applying for registration with CANNN for the sole purpose of providing nursing care by virtual/telehealth to NWT/NU residents.	
I declare that I have completed a minimum of 1125 hours (NP) in the last 4 years.	
I declare I have completed a continuing competence/quality assurance plan in my home jurisdiction.	
_____ Signature	_____ Date