Ordre des infirmières et infirmiers du Québec

EQUIVALENCE | SNP

Attestation of Registration

The Office of the Admissions and Registrar

IDENTIFICATION OF THE APPLICANT

Permit number:

Last name: First name:

Birth name: Date of birth: AAAA-MM-JJ

If different from the last name

Address: Country:

City (Province): Postal code:

Email: Telephone:

REGULATORY AUTHORITY

This section must be completed by the organization which authorized the applicant to practise the speciality.

Name:

Address: Country:

City (Province): Postal code:

Representative:

Last name: First name:

Title:

Email: Telephone:

Certifies that the applicant identified above, holding the registration number:

Holds or has held the title of:

From the:

Issuance of this authorization to practice is mandatory for using the above-mentioned title: ◯ Yes ◯ No

If the registration was obtained following an examination, please specify which one:

This person has been or is subject to disciplinary action (licence revoked, suspended or otherwise): ◯ Yes ◯ No

If **Yes**, specify:

Please indicate reason and date

◯ I certify the accuracy of the information contained in this application.

◯ I authorize the Ordre des infirmières et infirmiers du Québec to proceed with its verification if necessary.

Signature:

Date of signature:

The form must be completed, signed, and returned to the applicant.

Please affix your seal or stamp in this space