Passport Photograph

THE NURSING & MIDWIFERY COUNCIL OF NIGERIA

INDEXING FORM: A & B

APPLICATION FOR ENTRY IN THE INDEX OF STUDENT NURSES/MIDWIVES/PSYCHIATRIC NURSES.

This form must be completed and returned to the Secretary-General Nursing and Midwifery Council of Nigeria, Murtala Mohammed Way, Central Medical Library Compound, Opp. Yaba Terminus, Yaba. P.M.B. 21194, Ikeja within six weeks of Admission as Student, with other relevant documents

1. **NAME OF APPLICANT** .....
Surname first (in capital letters) *other Names*

MARITAL STATUS .....

SEX:..... .....

ADDRESS OF TRAINING INSTITUTION:.....

.....

DATE ADMITTED TO TRAINING INSTITUTION:.....

DATE OF BIRTH:.....

PLACE OF BIRTH (L.G.A. :.....**STATE**.....)

RELIGION:.....

PERMANENT HOME ADDRESS:.....

.....**Tel. No**.....

NAME AND ADDRESS OF SPONSOR :.....

.....**Tel. No**.....

NAME AND ADDRESS OF NEXT OF KIN :.....

.....

2. Please attach the following to support your application
   (A) A certified copy of Birth Certificate or Statutory Declaration of Age.

   (B) A copy of detailed WASC/GCE result endorsed by the appropriate Education Authority as Evidence of Educational Qualification

   (c) A copy of testimonial from the Principal of last School attended

   (D) Two recent passport size photographs (black & white)

   (E) Copy of Marriage Certificate/Affidavit (if Married)

(f) A copy of Notification of Registration/Certificate of Registration as a Nurse/Midwife or Psychiatric Nurse issued by the Nursing and Midwifery Council of Nigeria (If applicable).

(FOR POST-BASIC STUDENTS ONLY)

3. To be completed by: POST-BASIC STUDENTS ONLY.

A.....

B.....

C.....

PREVIOUS EMPLOYMENT (IF ANY)

Name and Address of Employer:.....

.....

Position held with dates:.....

4. DECLARATION BY THE APPLICANT:

I hereby declare that the information given in this application is correct to the best of my knowledge.

Date:..... Signature of Applicant:.....

5. CERTIFICATION BY THE HEAD OF TRAINING INSTITUTION

Name of Principal/Head of Training Institution:.....

.....

DESIGNATION:.....

ADDRESS OF TRAINING INSTITUTION:.....

.....

(Delete what is not appliable)

Type of training programme: Nursing/MIdwifery/Psychiatric Nursing
I hereby certify that the information given by the applicant is correct:

Signature of Principal:.....

Date:.....

(Please use official school stamp to authenticate this form)

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