لمباڬا جورواوت باڬي برونې

NURSING BOARD FOR BRUNEI

"Protecting the Health and Well Being of the Public"

FORM-B

Office: Nursing Board for Brunei
2G5:02, Level 5,
Ong Sum Ping Condominium,
Ong Sum Ping, BA1311
Bandar Seri Begawan
Brunei Darussalam

Website: www.moh.gov.bn
Email: nursing.board@moh.gov.bn
Tel: +673-2237304

APPLICATION FOR RENEWAL OF PRACTISING CERTIFICATE YEAR ☐☐☐☐

This application will not be considered unless it is complete and all supporting documentation has been provided. Only submission of original application form is accepted.

Privacy and Confidentiality

The Nursing Board for Brunei are committed to protecting your personal information as private and confidential.

Completing this form

- Read and complete all sections.
- Use a **BLUE PEN** only.
- Print clearly in BLOCK LETTER
- Place ☑ in all applicable boxes : ☐

REGISTRATION NUMBER ☐☐-☐☐☐☐

PERSONAL DETAILS

Full Name									
Brunei ID							Nationality		
Marital Status	Single	☐	Married	☐	Divorced	☐	Widowed	☐	Religion

CONTACT DETAILS

Residential Address			
		Postcode	
Contact No.	Mobile:	E mail	

CURRENT PLACE OF PRACTICE

Sector	Public	☐	Private	☐
Employer				
Hospital / Institution				
Section (Department / Unit / Ward / Area etc.)				
		Designation/Appointment		

NEXT OF KIN

Relationship			
Full Name			
Brunei ID		Nationality	
Contact No.	Mobile:	Home:	Work:

DECLARATION OF APPLICANT

1. Have you ever been or are you currently the subject of an inquiry or an investigation by any licensing authority in Brunei Darussalam or other countries with regards to professional misconduct, clinical malpractice or negligence claim?	YES ☐ NO ☐
2. Have you ever suffered or are you suffering from any physical or mental illness which impairs your fitness to practise as a Registered Nurse / Assistant Nurse?	YES ☐ NO ☐
3. Have you ever been convicted in Brunei Darussalam or elsewhere of any offence?	YES ☐ NO ☐

✓ I hereby declare that to the best of my knowledge and belief the information provided above and the attached documents are true and authentic.

✓ I acknowledge that the Nursing Board for Brunei (NBB) reserves all rights to withhold and/or terminate my registration and/or take any action it deems fit if any of the above information or documents tendered is found subsequently to be false.

✓ I am also aware that it is a **criminal offence** to make any false statements, to provide any false information and or document(s) to NBB under Section 9 of Nurses Registration Act, Cap 140, **punishable** with a fine of BND 6,000.00 and imprisonment for twelve (12) months.

✓ I hereby also authorize the NBB and Boards Management Office (BMO) to release any information and/or relevant documentation provided by me to the other parties for the purposes of their official duties under current legislations.

Signature of applicant:

Date ☐☐-☐☐-☐☐☐☐

FOR OFFICE USE ONLY

Payment for renewal of PC

Payment Method	Cash ☐	BIBD Quick Pay ☐		BIBD Online ☐		Cheque ☐	
Amount	$	Receipt No.				Date	

Late renewal of PC

Amount	$	Receipt No.		Date	
Overdue by	days	Renewal Approved ☐		Renewal Rejected ☐	
Remarks					

Received by:

Name		Signature		Date	

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

QUALIFYING PERIOD	Start Date		End Date	

Please provide information for each learning activity until required minimum CPD points is achieved

Dates	Topic(s) / Title(s)	Organiser(s)	Type	No.of Hours	CPD Points

*Please add a separate copy as necessary.

NOTE:
Topic / Title : Name of the session or particular topic / title etc.
Type : Attendee / Speaker / Online learning etc.
CPD points : 1 hour session is equivalent to 1 CPD point. Some activities may also be in point-based system.

TO BE VERIFIED BY THE HEAD OF THE UNIT OR ITS EQUIVALENT.

Name	
Job Title	
Contact Number	
Email	

CRITERIA

CPD Point Achieved

YES ☐

NO ☐ IF NO, Pease specify reason:

Satisfacotry Individual Performance Appraisal or others:

YES ☐ Grade: _____

NO ☐ IF NO, Pease specify reason:

Medical Fitness

YES ☐ Valid Unitl: _____

NO ☐ IF NO, Pease specify reason:

DECLARATION

I confirm that _____
has demonstrated that he/she has complied with all of NBB practising certificate / license renewal requirements as per Standard of Registration.

I agree to be contacted by NBB to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse's renewal application at risk.

Signature	*Official Stamp*
Date	