



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  
addrs \_\_\_\_\_

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



Applicant's No. \_\_\_\_\_

## 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/1<sup>st</sup> Level Nurse /Staff Nurse ☐ Registered Midwife/1<sup>st</sup> Level Midwife

☐ Practical Nurse/2<sup>nd</sup> 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: \_\_\_\_\_



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)