BCCN&M British Columbia College of Nurses & Midwives

900--200 Granville St.
Vancouver, BC V6C 1S4

Tel: 604.742-6200
Toll-free 1.866.880.7101
Fax: 604.899.0794
www.bccnm.ca

Institutional Request for Certificate of Professional Conduct

Institution Information

Name of Institution	Vancouver Island Health Authority
Address	1952 Bay St, Victoria BC V8R 1J8
Name of Requestor	Medical Affairs
Title	Credentialing Coordinator
Telephone	250-370-8000
Email	credentialing_office@islandhealth.ca
Date	

Institutional Request

To the Registrar,

_____ has applied for hospital privileges at the
NAME OF NURSE PRACTITIONER

_____
NAME OF HOSPITAL

Please provide the Certificate of Professional Conduct covering the following information:

1. The registrant's BCCNM identification/registration number.
2. The registrant's initial BCCNM nurse practitioner registration date.
3. The registrant's current registration status with BCCNM and nurse practitioner category.
4. The name and type of nurse practitioner program completed by the registrant and registrant's completion date.
5. Any conditions placed on the registrant's registration as recorded on the Register.
6. Information whether registrant has had registration revoked, suspended, restricted to terms, limits, or conditions as a result of BCCNM's professional conduct review process.
7. Statement regarding whether the registrant's registration is in good standing.
8. Whether any restriction or cancellation of privileges by a Board of a hospital in British Columbia, because of incompetence, negligence or any form of professional misconduct, appears in the records of the College.
9. Any other information respecting the registrant which has been reported to BCCNM and which the Registrar deems to be relevant to an application for hospital privileges.

OVER . . .

Consent for Release of Information

I, _____, _____,
PRINT NAME BCCNM ID NUMBER

a registrant of the BC College of Nurses and Midwives, have read and understood the attached request for a Certificate of Professional Conduct and the description of information to be included in the Certificate. I further understand that BCCNM will not release this information unless I consent by signing this Consent Form.

I hereby consent to the release by the Registrar of the BC College of Nurses and Midwives to the

Vancouver Island Health Authority of the information
NAME OF INSTITUTION

described in the attached request for a Certificate of Professional Conduct, and I request the Registrar to provide a Certificate accordingly.

This Consent shall be irrevocable for 90 days from the date stated below.

Signature of Registrant _____

Print Name of Witness _____

Signature of Witness _____

Date _____

Please forward this form to Registration, by:

MAIL Registration
BC College of Nurses and Midwives
900 - 200 Granville Street
Vancouver, BC
Canada V6C 1S4

FAX 604.899.0794

EMAIL register@bccnp.ca