### **SINGAPORE NURSING BOARD**

**ADVANCED PRACTICE NURSE RETURN TO APN PRACTICE FORM**

**A. PARTICULARS OF APPLICANT**

|  |  |
| --- | --- |
| Full Name (as it appears on NRIC/Passport) (IN BLOCK LETTERS) (Please underline Family Name) | SNB Registration Number: |

**B. INFORMATION ON PREVIOUS APN CERTIFICATION WITH SNB**

|  |  |
| --- | --- |
| Type of APN Certification:  🞏 Full 🞏Conditional | Date of Last Certification: |
| Area of Practice During the Last Certification(Please specify discipline)   * Acute Care * Medical/Surgical. Specify sub-discipline:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Mental Health. Specify sub-discipline:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Community * Medical/Surgical (Paediatrics) |

**C. LICENSE TO PRACTISE AS NURSE PRACTITIONER/ ADVANCED PRACTICE NURSE (OVERSEAS)**

|  |  |  |
| --- | --- | --- |
|  | Country 1 | Country 2 |
| Country of Licensure |  |  |
| Council/Board providing license to practise |  |  |
| License Type |  |  |
| License No. |  |  |
| First Registration Date |  |  |
| License/ PC Start and Expiry Date |  |  |

**D. CERTIFICATION AS NURSE PRACTITIONER/ ADVANCED PRACTICE NURSE (OVERSEAS)**

|  |  |  |
| --- | --- | --- |
|  | Certification 1 | Certification 2 |
| Certification Country |  |  |
| Certification Type |  |  |
| Certification Start Date |  |  |
| Certification Expiry Date |  |  |

**E. WORKING EXPERIENCE AS RN AND/OR APN (OVERSEAS)**

*Please provide the work testimonial & clinical practice hours for each job experience*

|  | Experience 1 | Experience 2 |
| --- | --- | --- |
| Country |  |  |
| Employer |  |  |
| Duration of Employment |  |  |
| Designation |  |  |
| Ward/ Setting/ Department  *(if applicable)* |  |  |
| Name/s of Collaborating Physician/ Clinical Supervisor  *(if applicable)* |  |  |
| Patient Profile  *(if applicable)* |  |  |
| Clinical Duties and Responsibilities/Job Summary |  |  |
| Procedures  (*if applicable*) |  |  |

**F. PROPOSED SCOPE OF APN PRACTICE FOR RE-CERTIFICATION**

|  |  |  |
| --- | --- | --- |
|  | Previous (When last certified as APN with SNB) | Proposed |
| APN Certification: Area of Practice | *Same as Section B* |  |
| Employer |  |  |
| Duration of Employment |  |  |
| Designation |  |  |
| Ward/ Setting/ Department |  |  |
| Name/s of Collaborating Physician/ Clinical Supervisor |  |  |
| Patient Profile |  |  |
| Clinical Duties and Responsibilities/Job Summary |  |  |
| Procedures  (*if applicable*) |  |  |

*Note: For sections D, E and F, please provide separate attachments if required.*

**G. COMPETENCY TO PRACTICE *(please elaborate what training will be provided to help you to acquire the new competencies)***

| Period | Total Hours | Area of Training  (Ward/ Clinic) | Type of Training (Theory/ Knowledge/ On the job Training/ Clinical Attachment) | Disciplines/ Types of Cases | Name of Clinical Supervisor/ Preceptor |
| --- | --- | --- | --- | --- | --- |
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*(as at Aug 2017)*