INAMA Y'IGIHUGU Y'ABAFOROMOKAZI, ABAFOROMO N'ABABYAZA
NATIONAL COUNCIL OF NURSES AND MIDWIVES
CONSEIL NATIONAL DES INFIRMIERES, INFIRMIERS ET DES SAGES-FEMMES
P.O BOX 4259 KIGALI MOB. TEL: (250) 0788386969 E-mail: info@ncnm.rw

Verification of Qualification Request:

A. To be completed by applicant

Surname and first name .....

Other names ..... Date of Birth ...../...../.....

Professional title: ..... Registration /License № .....

National ID/Passport №:.....

Personal address:

Name: ..... Street: .....

District: ..... Province: .....

Country: .....Postal Code (if applicable) .....

E-mail address: ..... Tel:.....

B. To be Completed by the Educational Institution

Professional Information

This is to certify that .....born on...../...../..... commenced her/ his nursing/ midwifery course and had nursing/midwifery instructions in theory and practice at .....(provider institution). She/ he was issued with a certificate/ diploma№.....on ...../...../....., after having successfully passed the institution's final year examinations final state examinations ☐

The qualification was awarded upon completion of Nursing/ Midwifery Programme: Certificate (A2) ☐

Diploma (A1) ☐ BScN (A0) ☐ MScN ☐ PHD ☐

The nursing/midwifery programme was accredited by (please, mention the accrediting authority) .....on ...../...../..... .

Name: ..... Signature.....

Title:.....

Educational/ Training Information

Seal or Official stamp