



# DELHI NURSING COUNCIL

A B College Nursing Building ,L.N.Hospital, New Delhi – 02

## APPLICATION FORM FOR REACTIVATION

One  
Photograph  
Self-Attested

### DNC Registration No. :

1. Surname.....First Name.....Middle Name .....  
(Write in capital letter)
2. Father's Name .....
3. Mother's Name .....
4. Husband's Name.....
5. Gender: Female Male                      6.Marital Status: Single Married
7. Date of Birth: \_\_DD\_\_MM\_\_\_\_YYYY      8. Place of Birth: .....
9. Nationality: .....10. Email .....
11. Present Address .....  
.....Phone No. ....
12. Permanent Address: .....  
.....
13. General Qualification:.....
14. Name & Address of the Institution where nursing education was obtained: .....  
.....
15. Programme of study completed(B.Sc./GNM/ANM/MPHW(F)/LHV/Health Supervisor).....  
a. Date of Joining: \_\_DD \_\_MM\_\_\_\_YYYY b. Date of Completion: \_\_DD \_\_MM\_\_\_\_YYYY
- 16.1 Name & Address of the Examining Body.....
- 16.2 Date of Qualifying Examination \_\_DD \_\_MM\_\_\_\_YYYY Roll No.: .....
- 17.1 Name of the Nursing registration Council with which registered already .....  
.....
- 17.2 Registration No. RN/RM.....Date of Removal from register(if any)\_\_DD \_\_MM\_\_\_\_YYYY
- 17.3 Date of reinstatement \_\_DD \_\_MM\_\_\_\_YYYY Higher Professional Qualifications.....

I hereby declare that the information given above is true to the best of my knowledge and that there are no instances of adverse professional conduct against me that could render me ineligible for registration as Registered Nurse / Registered Midwife / MPHW (F) / LHV with Delhi Nursing Council.

Date..... Place.....Signature of Applicant.....

**For Office Use Only**

Application Checked by.....

Registration fee paid Vide receipt No.....Date...../...../.....Registration

Number Alloted .....Date .....

Place.....

**Signature of Registrar**