s

Delhi Nursing Council

A.B. College Nursing Building, L. N. Hospital,
New Delhi – 110002

Application Form For Re-Registration

One Photograph Self-Attested

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: ..... (Attach copy of 10th Certificate).

8. Place of Birth: ..... 9. Nationality: .....10. Email Id .....

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: ..... b. Date of Completion .....

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) ...../...../.....

17.3 Date of reinstatement ..... Higher Professional Qualifications.....

18. Name & Address of the Employer (if working presently) .....

.....

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 .....

DELHI NURSING COUNCIL

Ahilya Bai College of Nursing Building
Lok Nayak Hospital, New Delhi-110002

SELF-DECLARATION FOR RECIPROCAL REGISTRATION
(Under the Delhi Nursing Council (Ease of Reciprocal Registration) Directive, 2026)

I,_____ Son/Daughter of _____,

residing permanently at _____,

and currently residing at_____,

do hereby solemnly affirm and declare as under:

Professional Qualification: I hold a recognized nursing qualification, namely _____ [ANM/GNM/B.Sc. Nursing/Post Basic B.Sc. Nursing/M.Sc. Nursing], completed in the year ____ from_____ [Name of College/Institution/University].

Parent Council Registration: I am actively and validly registered as a nursing professional with the _____ [Name of Parent State Nursing Council] with the following details:

- **Registration Number:** _____
- **Date of Registration:** _____
- **Validity/Expiry Date (if applicable):** _____

National Register (NRTS) Details: I am registered under the Nurses Registration and Tracking System (NRTS) of the Indian Nursing Council with **NRTS ID:** _____.

I desire to register and practice my profession as a nursing practitioner within the National Capital Territory (NCT) of Delhi.

I declare that there are no pending disciplinary proceedings, criminal cases, or malpractice inquiries against me by my parent and concern State Nursing Council, any court of law, or any other regulatory authority. My license to practice has never been suspended or cancelled.

I declare that all information, certificates, and credentials submitted by me on the official Delhi Nursing Council Registration Portal are true, correct, and authentic.

Consent for Verification: I hereby give my consent to the Delhi Nursing Council to independently verify my active credentials through digital backend integration with my parent State Nursing Council and the Indian Nursing Council's NRTS live register.

Acknowledgment of Liability: I fully understand that if any information or document provided in this self-declaration is found to be false, fraudulent, or misrepresented, my application/registration will be immediately invalidated. I also acknowledge that I will be liable for strict legal action and penalties under Sections 26, 27, 28, 29, and 30 of the Delhi Nursing Council Act, 1997, and other applicable laws.

I Agree: I hereby confirm that I have read, understood, and agree to the terms of this Self-Declaration.

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