Nursing Council of Kenya Promoting quality nursing education and practice in Kenya



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Kabarnet Lane, off Ngong Road.Nairobi

Health Facility Nurse Returns Form

NB: This return form shall be submitted to the Nursing Council of Kenya by 1st of July each year.

	Name of Health Facility	Name of Health Facility							
	Name of the Health Fac	ility Supervisor:	Contact details:						
County			Sub county						
Facility Postal Add	lress:		email address						
Telephone / mobil	le Number								
Health Facility Bed	d Capacity		Average Bed Occupancy						
	Total No. of Nursing sta	aff:							
	No of: 1. BSCNs	2.KRCHNs		3.KRN/M	4.KRN/PSY				
	5.KRN	6.KECHN		7.KEN					
	Total No. of Nurses wit	h specialized training:							
	1. KRM	2. KRPsy/KEPsy	3. KRPaeds	4. KRA/E	5.KRAnaesthesia				
	7. KRNephrology	8. KROncology	9.KRPalliative	10.KRPaedsCCN	11.KEM				
	12. KRCCN	13. KRPeri-Op	14. KRCHN (PB)						
	Others: 1. Masters	Others: 1. Masters			(make a separate list of specialities)				
	No of CPD Coordinators	S							
	Total No. of student me	entors/ preceptors							
	Hospital Average Nurse	: patient ratio							

Average N	urse: pa	atient ratio per war	d as enumerated l	pelow					
Maternity ward (overall)		Labour ward		NBU			Postnatal ward		
Medical ward		Critical care unit		Renal unit					
Surgical ward		Outpatient departm		Accident & Emergency unit					
Paediatric ward		Amenity ward		MCH/FP					
Gynaecology ward		High dependency U							
Others									
Provide info	rmation	on NURSING STAFF us	ing the table below (A	An additional piece	of paper may be u	ised in case the	space provided is r	ot adequate):	
NAME and Mobile Number Level of Educar	of tion	Professional Qualification (Cadre)	NCK Registration No.s	Workstation	Working Experience (Yrs)	Practice License No.	Expiry Date	Email Address	
Diplon									
						1			
						1			

Declarati	on				•						
I hereby declare that the foregoing information is true and correct to the best of my knowledge.											
Health Facility Nursing Supervisor [Please include Official Stamp]											
Name: Designation:					Signature:						
	I hereby	Health Facility Nursing	I hereby declare that the foregoing information of the last the	I hereby declare that the foregoing information is true and con-	I hereby declare that the foregoing information is true and correct to the best Health Facility Nursing Supervisor [Please include Official Stamp]	I hereby declare that the foregoing information is true and correct to the best of my knowledge. Health Facility Nursing Supervisor [Please include Official Stamp]	I hereby declare that the foregoing information is true and correct to the best of my knowledge. Health Facility Nursing Supervisor [Please include Official Stamp]	I hereby declare that the foregoing information is true and correct to the best of my knowledge. Health Facility Nursing Supervisor [Please include Official Stamp]	I hereby declare that the foregoing information is true and correct to the best of my knowledge. Health Facility Nursing Supervisor [Please include Official Stamp]		