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



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Kabarnet Lane, off Ngong Road.Nairobi

Nurse Training Institution Returns Form

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

General Information	n [PRINT]									
Official Names of Trai	ining Institut	tion:								
Province:						County:			District:	
Postal Address:	Address		-	Code		Town	Institutional Email Add	ress:	@	
Telephone No:						Institutional I	Mobile No:			
Date of institution's ap	oproval to tr	ain nurses	3:		dd	mm	уууу			
Date of last visit made	e by the Nur	rsing Coun	ncil to your	r institution:	dd	mm	уууу			
Training Programm	es [PRIN]	Γ]								
List the nursing prog	grammes r	un by you	ır instituti	ion using the	e table below (An additional p	iece of paper may be ι	used in case the s	space provided is	not adequate):
Programme Date of Programme App		e Approval			e, Upgrading - Full Time, g-Print, Upgrading-	No. of Intakes	No. of Students per Intake	Total No of Students in the Programme [during reporting year]		
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Pre-Service: Upgrading: Post-Basic: Crand Total: List the approved health facilities utilized by students for practical experience (An additional piece of paper may be used in case the space provided is not adequate): Programme Name of Health Facilities Approved for Cinical Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Programme Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Community Health Experience Name of Health Facilities Approved for Commun	Provide total No. of Student N	lurses [during reporting	year]:							
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	Names	Education [Diploma, Degree,		Registration No.	Area of Teaching		the Area of		Mobile No	Email Address

Provide information on PART-TIME TUTORS using the table below (An additional piece of paper may be used in case the space provided is not adequate):									
Names	Highest Level of Education [Diploma, Degree, Masters etc]	Professional Qualifications	Registration No.	Area of Teaching	Years in the Area of Teaching	Work Station	Practice License No.	Mobile No	Email Address
Declaration									
I hereby declare that the foregoing information is true and correct to the best of my knowledge.									
Head of Nursing Department [Please include Official Stamp]									
Name:	Signature:								