



REQUEST FOR VERIFICATION OF REGISTRATION/ENROLMENT

Date: _____ Reference No: _____

Phone (Wk) _____ (Hm) _____ Mobile _____

Email: _____

Surname: _____ Given Names: _____

Address for Receipt: _____

Post Code: _____

Verification to be sent to: _____

Post Code: _____

Signature: _____

The prescribed fee of \$15.00 must be remitted with this request to the:
Nurses Board of South Australia, PO Box 2809, Kent Town SA 5071

Cheques/Money Orders made payable to the: **NURSES BOARD OF SOUTH AUSTRALIA**

Fee of \$ _____ is enclosed payable by Cheque / Money Order / Credit Card.

Cheque Money Order Credit Card

Please debit my credit card, details as follows:

Visa MasterCard Amex Diners Club

Card Number

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Expiry Date

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 For the amount of \$ _____

Signature _____ Date _____

Name Printed _____

Please ensure details are CLEAR, ACCURATE AND COMPLETE

Trim/01/12491
Apr08