



SOUTH AFRICAN NURSING COUNCIL
NOTIFICATION OF COMPLETION OF TRAINING
EDUCATION AND TRAINING FOR THE DIPLOMA IN
COMMUNITY NURSING SCIENCE

Government Notice No. R.276 of 15 February 1980 (as amended)

- **This information must be provided by the Person in charge of the Nursing Education Institution**
- **Incomplete and incorrect forms will not be processed**

1. DETAILS OF THE NURSING EDUCATION INSTITUTION

Name (as approved by Council)	
Correspondence Number (S- File No.)	
Accreditation certificate number	
Physical address	Postal address
Postcode	Postcode
Telephone Number(s)	
Fax Number	
E-mail Address	

2. DETAILS OF PERSON IN CHARGE OF NURSING EDUCATION INSTITUTION

Name of Person In Charge of the Nursing Education	
SANC Reference Number	
Professional Qualifications (not academic qualifications)	

3. NAME OF UNIVERSITY OF AFFILIATION / ASSOCIATION (IN CASE OF COLLEGE OR NURSING SCHOOL)

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4. LEARNER DETAILS				FOR OFFICE USE		
Surname						
Given Names in full (according to ID/Passport)						
SANC Reference Number						
SA Identity Document Number						
OR (if foreign)	Passport Number					
	Country of issue					
Date of Commencement		(Year)	(Month)	(Day)		
Date of Resumption (if applicable)		(Year)	(Month)	(Day)		
Date of Completion		(Year)	(Month)	(Day)		
5. RECORD OF EDUCATION AND TRAINING (N.B. TRANSLATE COUNCIL PERIOD TO HOURS)						
5.1. Total Theory		Prescribed Periods & Hours		Achieved Hours	For office use	
		By SANC	NEI			
- Scientific Foundations of the Community						
- Administrative Aspects of Community Nursing						
- Psychosocial and Cultural Aspects of Community						
- Community Nursing & Community Nursing Process						
- Other (specify)						
Total						
5.2 PRACTICA						
5.2.1 Practice area		Approved	Achieved Hours		Total	For office use
Minimum total = 320hours			<i>Day</i>	<i>Night</i>		
Health Education						
Environmental Control						
Mother & Child Services including preschool child						
School Health Services						
Occupational Health Services						
Geriatric Health Services						
Neonatal Care Services						
Prevention and control of communicable diseases						
Health Assessment Treatment and Care						
Rehabilitation						
Community Resource						
Other (specify)						

5.3 SUMMATIVE ASSESSMENT OUTCOMES/YEAR MARK

Theory	Practica	For office use
Other (specify)		

5.4 COURSE CODE NAMES CODE FOR OFFICE USE

5.4 COURSE CODE NAMES	CODE	FOR OFFICE USE

6. APPROVED / ACCREDITED CLINICAL FACILITY USED FOR PLACEMENT

Name of Clinical Facility	From	To	For office use
Other (specify)			

7. LEAVE GRANTED For Office Use

TYPE OF LEAVE (vacation, sick, etc.)	FROM (Full dates)	TO (Full dates)	For Office Use

Declaration that a learner has met the educational requirements to be registered as a Community Health Nurse**Learner details**

Surname _____
 Given names in full _____
 SANC reference number _____
 South African identity document number _____
 OR Passport number _____
 Country of issue _____

Training details(*)

Name of Institution: _____

Date of commencement	Year: _____	Month: _____	Day: _____
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Date of completion	Year: _____	Month: _____	Day: _____
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Declaration by Person in charge of nursing education programme

I hereby declare that the aforementioned learner:

- Has complied with all the prescribed minimum education and training programme requirements for registration as a Community Health Nurse in terms of Government Notice No. R.276 of 15 February 1980 (as amended); and
- Has been assessed and found to have the required competencies as per the prescribed teaching guide to practice in accordance with the prescribed scope of practice of a Registered Nurse.

I further declare that:

- The information provided is accurate and based on the authentic education and training records of the said learner;
- All the education and training of the learner were accurately recorded for the duration of the programme;
- The nursing education institution has in its possession all the original education and training records, including but not limited to assessment and clinical records;
- There is no evidence that such training records were tampered with or are in any way fraudulent; and
- In the event that any tampering of the record or fraudulent records are detected after this declaration is made, I undertake to immediately notify the Council thereof in writing.

I fully understand the meaning and implications of this declaration(**)

Full names (Print) _____
 Designation _____
 SANC reference number _____
 Signature _____
 Date _____

Declaration by Person in charge of nursing education institution

I declare that the information provided is accurate and based on the authentic education and training records of the said learner.

I fully understand the meaning and implications of this declaration(**)

Full names (Print) _____
 Designation _____
 SANC reference number _____
 Signature _____
 Date _____

Affix Stamp of the Nursing Education Institution here

(*) Any entry into the register made in error or through misrepresentation will be deleted/removed from the register.

(**) Any person that makes a false declaration or misrepresents the facts or information given in this declaration may be charged with an offence in terms of sections 46 and 54 of the Nursing Act, 2005 (Act No. 33 of 2005).