SOUTH AFRICAN NURSING COUNCIL

NOTIFICATION OF COMPLETION OF TRAINING

EDUCATION AND TRAINING FOR THE COURSE LEADING TO ENROLMENT AS A NURSING AUXILIARY

Government Notice No. R.2176 of 19 November 1993 (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 Postcode	Postal address 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)	

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		
- Nursing History & Ethics				
- Elementary Anatomy & Physiology				
- Basic Nursing Care				
- Elementary Nutrition				
- First Aid				
- Introduction to Comprehensive Health care				
Total				

5.2 PRACTICA

5.2.1 Practice area	Approved	Achieved Hours		Total	For office use
Minimum Requirement = 1000min		***Day***	***Night***		
Medical Ward					
Surgical Wards					
Paediatric Wards					
Casualty & Out Patients Department					
Operating Theatre					
Other : (Specify)					
Total					

5.3 ASSESSMENT OUTCOMES: YEAR MARK		
Theory	**Practica**	**For office use**

6. APPROVED / ACCREDITED CLINICAL FACILITY USED FOR PLACEMENT	
Name of Clinical Facilities	**For Office Use**
Other (e.g. Day Visits)	

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

Declaration that a learner has met the educational requirements to be registered as a Nursing Auxiliary

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:
Date of completion	Year:	Month:	Day:

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 nursing auxiliary in terms of Government Notice No. R.2176 of 19 November 1993 (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 nursing auxiliary.

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).