



Verification of Employment Hours



Section 1: TO BE COMPLETED BY THE APPLICANT AND SENT TO THE EMPLOYER. Copies of this form may be made and distributed to all employers in the last 5 years.

Surname: _____ Given name: _____ Dates of Employment: FROM: _____
(DD/MM/YY)
Maiden name (if applicable): _____ TO: _____

I, _____, am applying to the Ontario Nurse Practitioner program. In order to process my application, the University to which I am applying is requesting your institution provide information with respect to my employment status. I hereby give my previous and/or present employer(s) consent to provide any and all information in its possession to the university to which I am applying regarding my type and length of employment.

Applicant signature: _____ Date: _____

Section 2: TO BE COMPLETED BY THE EMPLOYER. Please return the completed form to the applicant.

Name of Employee: _____ Dates of Employment: FROM: _____
(DD/MM/YY)
TO: _____

Total **RN** hours worked at your organization: _____

Total **RN** hours worked in **past five years** at your organization: _____

Name of Employment Agency: _____

City: _____ Province: _____
Country: _____ Telephone Number: _____

Please check the following type(s) employment setting where this employee has practised with your organisation:

- | | | |
|-------------------|------------------|--------------------|
| LONG-TERM CARE | ACUTE CARE | COMMUNITY CARE |
| Chronic Care | Medical/Surgical | Public Health |
| Rehabilitation | Mental Health | Visiting Nursing |
| Home for the Aged | Pediatric | Independent Clinic |
| Retirement Home | Maternal/Child | Community Clinic |
| Nursing Home | Other (specify) | Other (specify) |
| Other (specify) | | |

I hereby certify that the information given is true and complete.

Name (please print): _____ Title: _____

Signature: _____ Date: _____