

VERIFICATION OF EMPLOYMENT HOURS FORM

Students applying to the PHCNP Certificate program must complete at least 3640 hours within the last 5 years as a Registered Nurse prior to beginning the program in September. Please let us know where and when you completed your RN hours.

Section 1: THIS SECTION IS TO BE COMPLETED BY THE APPLICANT AND SENT TO THE EMPLOYER. PHOTOCOPIES OF THIS SHEET MAY BE MADE TO DISTRIBUTE TO ALL EMPLOYERS OF THE LAST 5 YEARS.

Last Name		Given Name(s)	
Date of Employment:	From YYYY/MM/DD	To YYYY/MM/DD	

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

Applicant Signature: _____ **Date:** _____

Section 2: THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER. PLEASE COMPLETE THIS SECTION RETURN THE DOCUMENT TO THE APPLICANT FOR SUBMISSION WITH THEIR APPLICATION PACKAGE.

Name of Employee:			
Date of Employment:	From YYYY/MM/DD	To YYYY/MM/DD	
Please Indicate Total Hours Worked:			
Employment Agency Name & Address			
		City	Province/State
Country	Postal or Mailing Code	Telephone Number	FAX

PLEASE CHECK THE FOLLOWING TYPE OF EMPLOYMENT SETTING(S) WHERE THIS EMPLOYEE HAS PRACTICED AT YOUR FACILITY:

<u>LONG-TERM CARE</u>		<u>ACUTE CARE</u>		<u>COMMUNITY CARE</u>	
Chronic Care	<input type="checkbox"/>	Medical/Surgical	<input type="checkbox"/>	Public Health	<input type="checkbox"/>
Rehabilitation	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Visiting Nursing	<input type="checkbox"/>
Home for the Aged	<input type="checkbox"/>	Pediatric	<input type="checkbox"/>	Independent Clinic	<input type="checkbox"/>
Retirement Home	<input type="checkbox"/>	Maternal/Child	<input type="checkbox"/>	Community Clinic	<input type="checkbox"/>
Nursing Home	<input type="checkbox"/>	Other, please specify _____		Other, please specify _____	
Other, please specify _____					

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

Name (please print):

Title:

Signature:

Date:
