Starlite Gallery
302 – 7071 Bayers Road
Halifax, Nova Scotia B3L 2C2
Telephone: 1-902-423-8517
Toll Free (NS): 1-800-718-8517
Fax: 1-902-425-6811
info@clpnns.ca www.clpnns.ca

VERIFICATION OF PRACTICE HOURS

SECTION A: APPLICANT – Complete **Section A and** forward to the Director of Nursing or Human Resources at all of your employers within the last five years. Please make additional copies, if necessary.

_____

(Last Name) (First Name) (Middle Name) (Previous Name)

Dates of Employment: From _____ To _____

(dd/mm/yyyy) (dd/mm/yyyy

Applicant's Signature: _____ Date: _____

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SECTION B: EMPLOYER – To be completed by the employer of the applicant for registration and licensure with CLPNNS. This completed form must be returned directly to the **College of Licensed Practical Nurses of Nova Scotia** at Starlite Gallery 302 – 7071 Bayers Road Halifax, Nova Scotia, Canada B3L 2C2. Any costs associated with translation of documents are the responsibility of the applicant.

This is to verify that_____ is/was employed as _____

(Name of Employee) (Position)

by _____

(Name of Employing Agency) (Street Address) (City/Town)

_____ between _____ and _____.

(Province/Territory/State) (Country) (Postal Code/Zip Code) (dd/mm/yyyy) (dd/mm/yyyy)

Eligible for re-hire: Yes ___ No ___ (If **no**, please attach an explanation)

NUMBER OF HOURS WORKED IN PAST FIVE YEARS

YEAR	HOURS	Employment Status
Year 20__		**Full-time ____ / Part-time ____ / Casual ____**
Year 20__		**Full-time ____ / Part-time ____ / Casual ____**
Year 20__		**Full-time ____ / Part-time ____ / Casual ____**
Year 20__		**Full-time ____ / Part-time ____ / Casual ____**
Year 20__		**Full-time ____ / Part-time ____ / Casual ____**
Total		**Full-time ____ / Part-time ____ / Casual ____**

DECLARATION

I _____ declare that the information is true and that no professional, and/or

(Print Name)

safety issues have occurred to indicate that a license to practice Practical Nursing should not be issued.

Signature: _____ Position: _____

Telephone: _____ E-mail: _____ Date: _____