209 Blackmarsh Rd., St. John's, NL, A1E 1T1
709-579-3843
www.clpnnl.ca

FORM C VERIFICATION OF EMPLOYMENT

Applicant: Please complete Section A and forward to your employer(s). Make copies as necessary.

Section A:

CONSENT

I hereby give consent to the employer named below to provide information to the College of Licensed Practical Nurses of Newfoundland and Labrador for the purpose of verification of employment.

_______________________________ _______________________________ _______________________________
Print Name Signature Date (dd/mm/yy)

____
Employer

Employer: *The individual named in Section A above has applied for registration/licensure as a Practical Nurse in Newfoundland and Labrador. We would appreciate receiving the confidential information requested below.*

Please complete all blocks in Section B and mail original to the College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) at the address above.

Section B:

1. **EMPLOYER (Please Print)**

Name of Employer: ____

Address of Employer: ____

Dates of Employment: ____

Classification: ◯ LPN ◯ RPN ◯ RN ◯ PCW ◯ Other ______________________

Status: ◯ Permanent ◯ Temporary ◯ Casual

Full-time ◯ Yes ◯ No

2. HOURS WORKED

Please provide the number of hours worked for each of the licensure years listed below:

April 1, 2019 – March 31, 2020 ____

April 1, 2018 – March 31, 2019 ____

April 1, 2017 – March 31, 2018 ____

April 1, 2016 – March 31, 2017 ____

April 1, 2015 – March 31, 2016 ____

3. DISCIPLINE (Please Print)

Has the applicant ever been disciplined or allowed to resign in respect to a matter related to a patient, resident or client of your institution or agency?

◯ Yes ◯ No

If YES, please provide details.

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4. EMPLOYER REPRESENTATIVE COMPLETING VERIFICATION FORM

______________________	______________________	______________________
Signature	Print Name	Position
______________________	______________________	
Phone Number with Area Code	Date (dd/mm/yy)	