



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, 2016 – March 31, 2017	_____
April 1, 2015 – March 31, 2016	_____
April 1, 2014 – March 31, 2015	_____
April 1, 2013 – March 31, 2014	_____
April 1, 2012 – March 31, 2013	_____

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.

4. EMPLOYER REPRESENTATIVE COMPLETING VERIFICATION FORM

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