

**Ontario Primary Health Care Nurse Practitioner Program****Verification of Employment Hours****Section 1: TO BE COMPLETED BY THE APPLICANT AND SENT TO THE EMPLOYER. PLEASE PRINT**

Photocopies of this sheet may be made to distribute to all employers in last 5 years.

Surname: \_\_\_\_\_ Given Name(s): \_\_\_\_\_ Dates of Employment:  
 FROM: \_\_\_\_\_  
 DD/MM/YY  
 TO: \_\_\_\_\_  
 DD/MM/YY

Maiden Name (if applicable) \_\_\_\_\_

I, \_\_\_\_\_, am applying to the Ontario Primary Health Care Nurse Practitioner Program. In order to  
 PLEASE PRINT NAME  
 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: \_\_\_\_\_

**ATTENTION APPLICANT: DO NOT COMPLETE SECTION 2****Section 2: TO BE COMPLETED BY THE EMPLOYER AND RETURNED TO THE CANDIDATE IN A SEALED**

**ENVELOPE.** Please sign a sealed envelope to ensure confidentiality. Information obtained may be shared with the applicant separately if desired.

NAME OF EMPLOYEE: \_\_\_\_\_ Dates of Employment  
 FROM: \_\_\_\_\_  
 DD/MM/YY  
**TOTAL HOURS WORKED within the Last Five years:** \_\_\_\_\_  
 TO: \_\_\_\_\_  
 DD/MM/YY

EMPLOYMENT AGENCY NAME: \_\_\_\_\_  
 \_\_\_\_\_

CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_

COUNTRY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

TELEPHONE NUMBER ( ) \_\_\_\_\_ FAX NUMBER ( ) \_\_\_\_\_

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

LONG-TERM CARE:

Chronic Care   
 Rehabilitation   
 Home for the Aged   
 Retirement Home   
 Nursing Home   
 Other, please specify \_\_\_\_\_

ACUTE CARE:

Medical/Surgical   
 Mental Health   
 Pediatric   
 Maternal/Child   
 Other, please specify \_\_\_\_\_

COMMUNITY CARE:

Public Health   
 Visiting Nursing   
 Independent Clinic   
 Community Clinic   
 Other, please specify \_\_\_\_\_

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

Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_