COLLEGE OF
LICENSED PRACTICAL NURSES
OF NEWFOUNDLAND AND LABRADOR
LPNs - A Practical Approach to Quality Care

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 ◯ Unregulated Care Provider ◯ 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, terminated or allowed to resign due to their professional practice or any 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)	