RYERSON UNIVERSITY

COMBINED MASTER OF NURSING/PHCNP CERTIFICATE
ADMISSIONS APPLICATION (SUPPLEMENTARY FORM)

VERIFICATION OF EMPLOYMENT HOURS

Students applying to the combined MN/ PHCNP Certificate program must complete at least 3640 hours within the last 5 years as a Registered Nurse prior to beginning the program in September 2012. Please let us know where and when you completed your RN hours.

Section 1: THIS SECTION IS TO BE COMPLETED BY THE APPLICANT AND SENT TO THE EMPLOYER. PHOTOCOPIES OF THIS SHEET MAY BE MADE TO DISTRIBUTE TO ALL EMPLOYERS OF THE LAST 5 YEARS.

Last Name		Given Name(s)
Date of Employment:	From YYYY/MM/DD	To YYYY/MM/DD

I, _____ am applying to the Ontario Primary Health Care Nurse Practitioner Certificate program at Ryerson University. In order to process my application, Ryerson University is requesting your institution to provide information with respect to my employment status. I hereby give my previous and/or current employer(s) consent to provide any and all information in its possession to Ryerson University regarding my type and length of employment.

Applicant Signature: _____ Date: _____

Section 2: THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER. PLEASE COMPLETE THIS SECTION AND PLACE THE FORM IN YOUR INSTITUITION/ORGANIZATION ENVELOPE, COUNTERSIGN AND DATE ACROSS THE SEAL. EITHER MAIL THE SIGNED, SEALED AND DATED ENVELOPE TO: GRADUATE ADMISSIONS, RYERSON UNIVERSITY, 350 VICTORIA STREET, TORONTO, ONTARIO, CANADA M5B 2K3 OR RETURN THE ENVELOPE TO THE APPLICANT FOR SUBMISSION WITH THEIR APPLICATION PACKAGE.

Name of Employee:			
Date of Employment:	From YYYY/MM/DD	To YYYY/MM/DD	
Please Indicate Total Hours Worked:			
Employment Agency Name & Address			
		City	Province/State
Country	Postal or Mailing Code	Telephone Number	FAX

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

LONG-TERM CARE		ACUTE CARE		COMMUNITY CARE	
Chronic Care	☐	Medical/Surgical	☐	Public Health	☐
Rehabilitation	☐	Mental Health	☐	Visiting Nursing	☐
Home for the Aged	☐	Pediatric	☐	Independent Clinic	☐
Retirement Home	☐	Maternal/Child	☐	Community Clinic	☐
Nursing Home	☐	Other, please specify _____		Other, please specify _____	
Other, please specify _____					

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

Name (please print): _____ Title: _____

Signature: _____ Date: _____