# 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 five years.

<table>
<thead>
<tr>
<th>Dates of employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname: _________________________________</td>
</tr>
<tr>
<td>From: __________________________</td>
</tr>
<tr>
<td>To: __________________________</td>
</tr>
</tbody>
</table>

I, _________________________________ am applying to the Ontario Primary Health Care Nurse Practitioner Program at the University of Ottawa. To process my application, the University is asking your institution to provide information about my employment status. I give my previous and/or present employer(s) permission to provide any information in its possession to the University of Ottawa on the type and length of my employment.

Applicant signature: ________________________________________________ Date: ___________________________________________

**ATTENTION APPLICANT: DO NOT COMPLETE SECTION 2.**

### SECTION 2: TO BE COMPLETED BY THE EMPLOYER AND RETURNED TO THE APPLICANT.

<table>
<thead>
<tr>
<th>Dates of employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of employee: ____________________________________________________</td>
</tr>
<tr>
<td>Total hours worked in the last five years: ____________________</td>
</tr>
<tr>
<td>From: ______________________________</td>
</tr>
<tr>
<td>To: __________________________</td>
</tr>
</tbody>
</table>

Employment agency name: ___________________________________________________________

- No. and street: _________________________________
- City: ________________________
- Province: ________________________
- Country: _________________________________
- Postal code: __________________

Telephone: (            ) ________________________________ Fax: (            ) _________________________________

Please check the type of employment setting(s) your organization is best described as:

- Acute-care hospital, addiction and mental health centre/psychiatric hospital, complex continuing care/rehabilitation hospital, other hospital
- Long-term care facility, nursing home, home for the aged, retirement home
- Community Care Access Centre, community health centre, community mental health program, hospice, nursing/staffing agency, physician’s office, public health unit/department, school, group home, street health agency
- Independent practice; health care consultant agency; seasonal camp; occupational health services; industry; insurance, pharmaceutical or medical-supply company
- Health care education, nursing education program or research organization
- Government health agency, social services agency or nursing organization (labour, professional support, regulatory)

**Area(s) of nursing practice** the applicant was engaged in at your organization:

- Clinical
- Administration
- Education
- Leadership
- Research

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

Name (please print): _________________________________________________ Title: _________________________________

Signature: _________________________________________________ Date: _________________________________

**ONCE THE FORM IS COMPLETED, APPLICANTS MUST UPLOAD IT WITH THEIR ADMISSION APPLICATION VIA THEIR UOZONE ACCOUNT. IF YOU HAVE MORE THAN ONE FORM, PLEASE SCAN IN ONE DOCUMENT AND SUBMIT ALL FORMS IN ONE UPLOAD.**