uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

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.

Dates of employment

Surname: _____ Given name(s): _____ From: _____
DD/MM/YY

To: _____
DD/MM/YY

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 COMPETED BY THE EMPLOYER AND RETURNED TO THE APPLICANT.

Dates of employment

Name of employee: _____

From: _____
dd/mm/yy

Total hours worked in the last five years: ☐

To: _____
dd/mm/yy

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
- ❑ Education
- ❑ Research
- ❑ Administration
- ❑ Leadership

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.