LAKEHEAD UNIVERSITY
Master of Nursing - Nurse Practitioner Specialization
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 the last 5 years

Dates of Employment: FROM:_____ TO:_____
DD/MM/YY DD/MM/YY

Surname: _____ Given Name(s):_____

Maiden Name (if applicable): _____

Lakehead University ID number: _____

I, _____ am applying to the Master of Nursing - Nurse Practitioner Specialization program.
PLEASE PRINT NAME

In order to process my application, Lakehead University is requesting your institution to 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: Please ensure that both pages of this form are submitted together

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.

Dates of Employment FROM:_____ TO:_____
DD/MM/YY DD/MM/YY

Name of Employee_____

Total hours worked within the past five years _____

Name of Employer/Organization _____

City: _____ Province: _____

Country_____ Postal Code_____

Telephone _____ Email _____

PLEASE CHECK THE FOLLOWING TYPE(S) OF EMPOLYMENT SETTINGS
WHERE THIS EMPLOYEE HAS PRACTICED AT YOUR FACILITY AS A REGISTERED NURSE:

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 _____

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

Name (please print) _____

Title _____

Signature _____

Date _____

Please submit the completed form to:
LAKEHEAD UNIVERSITY
FACULTY OF GRADUATE STUDIES
955 OLIVER ROAD
THUNDER BAY, ON P7B 5E1