# Supervised Practice Experience (SPE) Completion FormCollege of Nurses of Ontario logo The Standard of Care

College of Nurses of Ontario

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**Instructions**

Step 1: The member participating in the Supervised Practice Experience (SPE) completes Section 1 of this form and sends the entire form directly to the employer/agency for completion of section 2

Step 2: The employer/agency completes Section 2 of this form and mails the entire form directly to the College of Nurses of Ontario in an official envelope bearing the employer/agency’s seal or stamp. Complete mailing address is at the top of this form.

Please review the *Privacy Code* on the College’s website ([www.cno.org/privacy](http://www.cno.org/privacy) ) to understand how your personal

information will be used.

## SECTION 1

###  Member Information

|  |  |  |  |
| --- | --- | --- | --- |
| First name       |  | Last Name |  |

Registration number

Category of registration: Registered Nurse [ ]  Registered Practical Nurse [ ]

Other (Please specify):

###  Date of SPE

Started:

dd/mm/yyyy

Completed :       (last shift worked) dd/mm/yyyy

###  Consent

In order to verify my evidence of practice requirement, the College of Nurses of Ontario is requesting that your institution provide information with respect to my SPE status.

I,       ,

Name of member participating in SPE

hereby give you consent to provide any and all information in your possession to the College of Nurses of Ontario regarding my SPE practice.

SPE Member’s signature:

Date:

dd/mm/yyyy

## SECTION 2

###  Employer/agency information Must be completed by employer/agency

First name

Address

City/Town Province Postal Code

Telephone number (include area code). Fax number (include area code)

1. Date of SPE Started:       Completed:

dd/mm/yyyy dd/mm/yyyy

1. During the SPE the member practiced as:

Registered Nurse [ ]  Registered Practical Nurse [ ]  Other:

Please specify

1. Position in nursing (e.g. staff nurse, clinical instructor):
2. Type of practice setting (e.g. Public Health, Chronic Care):
3. Type of patient population (e.g. Adults, Paediatric, Mental Health):
4. Primary language used in the applicant’s practice setting:
5. Primary language of the patient population for which the applicant provided nursing services:
6. Would you employ this person if you were able? Yes [ ]  No [ ]

If no, please explain why (Please attach an explanation if more space is needed):

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

Name:       Title:

Signature:

Date:      dd/mm/yyyy

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