Verification of Nursing Practice



THE STANDARD OF CARE.

College of Nurses of Ontario 101 Davenport Rd., Toronto, ON M5R 3P1 www.cno.org Telephone: 416 928-0900

Toll-free (Canada): 1 800 387-5526

Fax: 416 928-6507 Email: enp@cnomail.org

How to complete this form

Step 1: Applicant should complete section 1.

Step 2: The employer/agency should complete section 2.

Step 3: The employer/agency should return the fully completed form to the College of Nurses of Ontario (CNO) by email at enp@cnomail.org.

Important

CNO will not accept this document if sent by the applicant; it must be sent by the employer/agency directly to CNO.

Collection of Personal Information

Please review CNO's Privacy Policy to understand how your personal information will be used.

SECTION 1

Applicant's signature:___

Last name	Application number	
First name	Previous name(s)	
Applicant's mailing address	Date of employment: From: ()	
Apt/unit#	To: () (last shift worked)	
Province/State Postal/Zip Code Country Date of birth (MM/DDYYYY)	Category of employment Registered Nurse Registered Practical Nurse Other (please specify):	
I am s	eeking registration in Ontario.	

Date: _

DD/MM/YYYY

MARCH 2023

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Section 2 — Employer/Agency:

Please complete Section 2 of this form and send directly to CNO by email at enp@cnomail.org. Information may be shared with the applicant.

SECTION 2

To be completed by the employer/agency Attention applicant: Do not complete Section 2

Name of employer/agency	Province/State	Postal/Zip code	Country	
Address	Manager/superv	Manager/supervisor's direct phone number (include country code)		
City/town	Fax number (incl	Fax number (include country code)		
 Date of employment: From: () To: () Last shift worked: () Category of employment: □ Registered Nurse □ Registered Practical Nurse 	this language the applicance the applicance language the applicance language the applicance language l	 8. When providing nursing services in this language to these patients/clients, the applicant practiced nursing: Full-time (30 or more hours per week) Part-time (less than 30 hours per week) Casually (as needed) 9. Would you re-employ this person?		
Other (please specify):Position in nursing (e.g. staff nurse, Clinical Instructor):	if more space is	If no, please explain why (Please attach an explanation if more space is needed):		
5. Type of practice setting (e.g. Public Inchronic Care):	Health,			
 6. Type of patient population (e.g. Adu Mental Health): 7. What language did the applicant prireading, writing, speaking and lister health care or practice setting when nursing services and interacting with clients, and/or other healthcare prof 	I hereby certify complete: Imarily use for manage of ma	that the information giver	n is true and	
	Signature Date (DD/MM/YYYY	7		