## Nursing Practice / Employment Form

The following information from your application identifies you to the nursing organization/employer in the jurisdiction where you have been employed over the past [1-5] years.

Please ensure that the information is correct, and sign and date each copy of this form. All forms (one for each nursing organization/employer in the jurisdiction where you have been employed) must be mailed directly to CGFNS.

### Part A: Personal Information

CGFNS ID number: Order number:

My current name

First (given) name Middle name Last (family / surname) name

My other names

My current mailing address

Address

Address City

State / Province Post / Zip code Country

- **Date of Birth:** MM/DD/YYYY
- **Name of the facility or organization where employed:**

**Address of Employer**

---

- **Name of supervisor:**
- **Title/Position of supervisor:**

---

I hereby give my consent to you to provide the information requested in Part B of this form related to my Nursing Employment with this organization directly to CGFNS at the following address:

CGFNS International, Inc.
ATTN: Director of Credentials Evaluation
3600 Market Street, Suit 400
Philadelphia, PA 19104-2651 USA

**Your signature:**_____ **Current date:** _____
(Please sign your name) (Provide date in MM-DD-YYYY format)

## Part B: Employer Information

**Please provide the following information (in English) concerning the nursing practice/employment of this nurse. Please mail this form directly to CGFNS at the provided address.**

***Job title or position held:*** _____
(Provide the complete title of the job or the position held by this nurse)

***Job status -*** Choose from the following list:_____Full-time_____Part-time_____Casual_____Other, (explain): _____

***Please indicate the type of nursing program in which this nurse worked –***

RN program, LPN program, RPN progream Other, (explain): _____

***The year and the number of total hours for each of the last five calendar years worked, with Year 1 being the most recent calendar year worked (as applicable):***

Year **1 (2016)__hrs.**, Year **2 (2015)__hrs.**, Year **3** (**2014)__hrs.**, Year **4 (2013)__hrs.**, and Year **5 (2012)__hrs.**

***Date when this nurse started employment:*** _____

***Date when this nurse ended employment:*** _____

---

***Has this nurse ever been disciplined or allowed to resign:*** Choose_____Yes, or_____No

***What is the primary language used in this nurse's practice setting:*** _____

***What is the primary language of the patient population for which this nurse provided nursing services:*** _____

## Part C: Identification of Employer Supervisor

***Please provide the following information for the official/supervisor authorized to provide the employment information on this nurse.***

***Your printed name:*** _____
(Please print your complete name)

***Your title:*** _____
(Please indicate your official title)

***Your signature:*** _____ ***Current date:*** _____
(Please sign your name) (Provide date in DD-MM-YYYY format)

***Phone number:*** _____ ***Alternate phone number:*** _____
(Provide your number in format: 123-456-7890 and country code if outside Canada.) (Provide an alternate number where you c an be reached, if necessary)

***E-mail address:*** _____
(Please provide your personal e-mail address where you can be reached if there are questions about this information.)

---

***All information added to this form, or attached to this form is confidential.***