Yukon
Community Services

Professional Licensing & Regulatory Affairs
Phone: (867) 667-5111 • Fax: (867) 667-3609 • Email: plra@gov.yk.ca

VERIFICATION OF EMPLOYMENT PROFESSIONAL PRACTICE HOURS

FOR: PRACTICAL NURSE, PHYSIOTHERAPIST, REGISTERED PSYCHIATRIC NURSE

Professional practice hours refer to all hours worked in accordance with an individual's formal job description, but do not include vacation, sick time, leave of absence, or any other paid/unpaid non-practice hours.

Please have your employer complete the following:

SECTION A: APPLICANT

Complete Section A and forward to the Director of Human Resources at all of your employers within the last four years. Please make additional copies, if necessary.

Last Name	First Name	Previous Name

Street Address or PO Box	City	Territory / Province / Country

Email	Phone number (work or cell)

Employer	Occupation
	☐ Practical Nurse ☐ Physiotherapist ☐ Registered Psychiatric Nurse

Dates of Employment: From YYYY/MM/DD to YYYY/MM/DD

In order to process my application, Professional Licensing and Regulatory Affairs, the regulatory authority in Yukon, is requesting information in regard to my employment with your organization. I give consent to you to provide any and all information to Professional Licensing and Regulatory Affairs regarding my professional practice. This shall constitute your legal authority to provide this information and any other information Professional Licensing and Regulatory Affairs may request in regard to my application and verification of employment and professional practice hours.

Applicant's Signature	Date
	YYYY/MM/DD

SECTION B: EMPLOYER

To be completed by the employer (supervisor or human resource representative) of the applicant for registration and licensure.

This is to verify that _____ is/was employed as _____
NAME OF EMPLOYEE POSITION

by _____
NAME OF EMPLOYING AGENCY

_____
STREET ADDRESS CITY/TOWN PROVINCE/TERRITORY/STATE COUNTRY POSTAL CODE/ZIP CODE

between YYYY/MM/DD and YYYY/MM/DD .

Hours worked as a: ☐ Practical Nurse ☐ Physiotherapist ☐ Registered Psychiatric Nurse

2017: _____ 2016: _____ 2015: _____ 2014: _____

SECTION B: EMPLOYER *(continued)*

Other information:

I certify that the information given is true and complete.

Name (print)		Title and Professional Designation
Name of Employing Agency or Facility		Address
Phone	Fax	Email
Authorizing Signature		Date YYYY/MM/DD

This completed form must be returned with your application to:

By mail:
Professional Licensing & Regulatory Affairs (PLRA)
PO Box 2703, C-5
Whitehorse, Yukon, Y1A 2C6

In person:
307 Black Street
Whitehorse, Yukon

Personal information is collected, used, and disclosed under the authority of Section 29(a) and (c) of the *Access to Information and Protection of Privacy Act* and under the Act associated to the profession related to the license being requested. It will be used for the purposes of these acts and their regulations, and to determine eligibility for licensure. It will also be used to maintain a public registry and for research and statistical purposes related to human resource planning. The latter is shared in a non-identifiable form only. For further information about the collection of this information, contact Professional Licensing & Regulatory Affairs (PLRA) Branch of Community Services, Government of Yukon, by mail at P.O. Box 2703, Whitehorse, YT, Y1A 2C6, by phone at 867-667-5111, by fax at 867-667-3609, or by email at plra@gov.yk.ca.

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