



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 <input type="checkbox"/> Practical Nurse <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Registered Psychiatric Nurse | | |
| Dates of Employment: From <u>YYYY/MM/DD</u> to <u>YYYY/MM/DD</u> | | | |
| 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 <u>YYYY/MM/DD</u> | |

| 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 <u>YYYY/MM/DD</u> and <u>YYYY/MM/DD</u> . | | | | |
| Hours worked as a: <input type="checkbox"/> Practical Nurse <input type="checkbox"/> Physiotherapist <input type="checkbox"/> 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