NOVA SCOTIA COLLEGE OF NURSING

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Bedford, Nova Scotia B4B 0V2
Tel: 902-444-6726
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fax: 902-377-5188
registration@nscn.ca

STATEMENT FROM EMPLOYER

☐ LPN | ☐ RN | ☐ NP (CHECK ALL THAT APPLY)

SECTION A - APPLICANT

Complete Section A then forward to each of your employers for whom you have worked in the past 12 months or, if you have not worked in the past 12 months, your most recent employer. They should complete section B.

SURNAME	GIVEN NAMES	BIRTH/FORMER NAME
DATES OF EMPLOYMENT	FROM	TO
	MONTH/DAY/YEAR	MONTH/DAY/YEAR
DATE OF BIRTH	EMAIL ADDRESS	TELEPHONE NUMBER
EMPLOYEE # (IF APPLICABLE)	SIGNATURE	DATE

SECTION B - EMPLOYERS

The above nurse is applying for registration and licensure with NSCN. We ask that you complete the information below in relation to their **nursing employment** and confirm that you do not have any concerns about their competence, character, capacity, conduct or reputation that would indicate we should not issue them a nursing licence. You can return the completed form to NSCN by mail or email (contact information provided above). **Faxes are not accepted**.

THIS IS TO VERIFY THAT		
	NAME OF EMPLOYEE	
WAS EMPLOYED BY		
	NAME OF ORGANIZATION	POSITION HELD
BETWEEN	AND	
(MONTH/DAY/YEAR)	(MONTH/DAY/YEAR)	
MAILING ADDRESS		

Please provide the number of nursing practice hours this nurse worked during the following:

NOV 1/22 - PRESENT		NOV 1/19 – OCT 31/20	
NOV 1/21 – OCT 31/22		NOV 1/18 – OCT 31/19	
NOV 1/20 – OCT 31/21		NOV 1/17 – OCT 31/18	

Do you have any concerns about this nurse's capacity, competence or character that would indicate we should not issue them a nursing licence.	☐ Yes | ☐ No
If yes, please provide details:	

If this nurse has left your employ, would you re-hire them? Yes ☐ No ☐ N/A ☐

IF NO, PLEASE COMMENT:

SIGNATURE	NAME (PLEASE PRINT)	POSITION (PLEASE PRINT)
DATE	TELEPHONE NUMBER	EMAIL ADDRESS