COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

St. Albert Trail Place
13163 -146 Street
Edmonton, AB T5L 4S8

Phone 780.484.8886
Toll Free 1.800.661.5877
Fax 780.484.9069
www.clpna.com

VERIFICATION OF EMPLOYMENT

Complete Section 1 and forward it to your nursing employer. Section 1 is to be completed by the applicant; Section 2 is to be completed by the employer. Once completed, the original form (no photocopies) form must be issued directly from the employer to the CLPNA. Copies will not be accepted. Forms may be submitted by email to registration@clpna.com, or by mail to the address posted above.

SECTION 1 (completed by applicant)

PERSONAL (Please Print)

Current Legal Surname (Last Name) _____ Given Name (First Name) _____ Middle Name(s) _____

Maiden Name _____ Date of Birth (dd/mm/yy) _____ Gender: ❒Female ❒Male ❒Unspecified

Apartment / Box No. / Address or Street No. _____ City / Town / Village _____

Province/State _____ Country _____ Postal Code / Zip Code _____

Telephone No. _____ Cell No. _____ Primary Language _____

E-mail Address _____

CONSENT TO RELEASE INFORMATION

I am seeking registration as a Licensed Practical Nurse in Alberta. In order to process my application, the College of Licensed Practical Nurses of Alberta (CLPNA) is requesting information regarding my employment with your facility. I hereby give my consent to you to provide any and all information to the CLPNA regarding my competency in nursing practice. This shall constitute your legal authority to provide this information and any other information the CLPNA may request relevant to my application. I was employed with your facility between the dates of

Date Employment Commenced and Concluded (dd/mm/yy) _____ Signature _____ Date (dd/mm/yy) _____

PRIVACY STATEMENT

I acknowledge that the information collected in this form will be used for the purposes of assessing my application for registration. This information will be maintained on my file and may also be used to assess my application for renewal of my practice permit in the future or for the purposes a discipline proceeding under Part 4 of the Health Professions Act. Information collected in this form including geographical, education, and employment information may also be disclosed to non-profit organizations and institutions for the purposes of health policy making and health human resource planning. No other disclosure of this information will be made except in accordance with the provisions of the Health Professions Act, the Licensed Practical Nurses Professions Regulation, the Personal Information Protection Act, or as otherwise permitted by law.

Signature _____ Date (dd/mm/yy) _____

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SECTION 2 (To be completed by employer)

EMPLOYMENT CONTACT INFORMATION (Please Print)

Facility Name

Apartment / Box No. / Address or Street No.

City / Town / Village

Province/State

Postal Code / Zip Code

Country

Telephone No.

Fax No.

EMPLOYMENT DETAILS (To be completed by employer)

Start Date (dd/mm/yy)

End Date (dd/mm/yy)

Job Title/Position held by employee

Supervisor Name

Supervisor Job Title/Position

Has the employee ever been disciplined? ❒ Yes ❒ No

Has the employee ever been terminated? ❒ Yes ❒ No

If the employee has been disciplined and/or terminated, please indicate why this action was taken or attach a document explaining the details.

Last Name, First Name, Initials of Employee

Unit/Area of Responsibility (check applicable boxes):

❒Medical ❒Mental Health/Psychiatry
❒Surgical ❒Community
❒Obstetrics ❒Pediatrics
❒Gerontology/Long Term Care

❒Other_____

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SECTION 2 (continued)

EMPLOYMENT HOURS (Please Print: Also check applicable box)

Year Employed	Total Hours Worked	Employment Status
2023		❒ Full-time ❒ Part-time
2022		❒ Full-time ❒ Part-time
2021		❒ Full-time ❒ Part-time
2020		❒ Full-time ❒ Part-time

COMPLETION OF FORM (To be completed by employer)

Signature (do not print) _____ Print Name _____

Title/Professional Designation _____ Telephone _____

Email Address _____ Date (dd/mm/yy) _____

Please submit this completed form directly to the CLPNA by email registration@clpna.com or mail:

Registrar
College of Licensed Practical Nurses of Alberta
St. Albert Trail Place
13163 146 Street
Edmonton, Alberta T5L 4S8