College of REGISTERED PSYCHIATRIC NURSES of Alberta

EMPLOYER REFERENCE

SECTION A – APPLICANT ONLY:

Complete Section A **ONLY** and forward the form to your employer(s) for confirmation of employment.

First/Given Name	Middle Name	Last/Family Name	Registration Number

Date Of Birth	Other Surname(s)(your last/family name at birth, your maiden name or other former names):

Mailing Address

City	Province	Postal Code

Employer	Supervisor Name	Supervisor Title

Employer Mailing Address

City	Province	Postal Code

I give my consent to you to provide the information requested in Section B of this form and send it directly to the College of Registered Psychiatric Nurses of Alberta (CRPNA).

Date _____ Applicant's Signature _____

SECTION B – EMPLOYER ONLY: Confirmation of Employment

Please provide the following information concerning the Practice/Employment for the above-named psychiatric nurse and return this form **directly** to the College of Registered Psychiatric Nurses of Alberta (CRPNA) via email, mail, or fax.

NOTE: THIS IS NOT TO BE SENT BY THE APPLICANT

Job title or position held by this Applicant:	Name of the area or unit of practice in which this Applicant worked:

Job Status:	Date when this Applicant started employment: (month/day/year)	Date when this Applicant ended employment: (month/day/year)
◯ Full-Time ◯ Part-Time ◯ Casual		

Total practice hours worked in the last 5 years:	Would you rehire this applicant? ◯ Yes ◯ No

Name (please print your complete name) _____ *Title (please indicate your official title)* _____

Phone number (include country code if outside Canada) _____ *Email address* _____

Date _____ *Signature* _____

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