

Verification of Course Completion and Transcript Request Nurse Practitioner



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

College of Nurses of Ontario
101 Davenport Rd., Toronto, ON M5R 3P1
www.cno.org

Telephone: 416 928-0900
Toll-free (Canada): 1 800 387-5526
Fax: 416 928-6507

How to complete this form

Step 1: Applicant should complete section 1.

Step 2: The nursing school should complete section 2.

Step 3: The nursing school should return the fully completed form to the College of Nurses of Ontario (CNO) using the mailing address at the top of this form. See instructions in section 2 of this form.

Important

CNO will not accept this document if sent by the applicant; it must be sent by the school.

Collection of Personal Information

Please review the Privacy Policy on CNO's website (www.cno.org/privacy) to understand how your personal information will be used.

SECTION 1

To be completed by the applicant

Last name

Application number

First name

Previous Name(s)

Applicant's mailing address

School of Nursing

Apt/unit#

Name of Program completed

City

Registered Nurse
Nurse Practitioner
Nurse Practitioner-Adult
Nurse Practitioner-Neonatal
Nurse Practitioner-Paediatrics
Nurse Practitioner-Primary Health Care

Province/State

Postal/Zip Code

Country

Other _____

Date of birth (MM/DD/YYYY)

Gender: ☐ Female ☐ Male

I authorize _____ to provide the information requested in Section 2
Name of the School of Nursing

and any and all information in its possession to the College of Nurses of Ontario regarding my education. This shall constitute your legal authority to provide any and all information which the College of Nurses of Ontario shall request which may, in any way, be relevant to my application.

Applicant's signature: _____ Date: _____

MM/DD/YYYY

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Section 2—Nursing School: Please complete Section 2 of this form and provide an **official transcript** that includes a list of the grades achieved, a breakdown of hours of theory and clinical practice for each subject along with a copy of the course descriptions/outlines and outcomes of the program the applicant completed. Return to the College of Nurses of Ontario in an envelope bearing the letterhead, seal or stamp of the NP program.

SECTION 2

To be completed by the Nursing school Attention applicant: Do not complete Section 2

School of Nursing

Address

City/Town

Province/State Postal/Zip Code Country

Type of school (e.g. College, Hospital, University, Vocational)

Telephone number (include country code)

Fax number (include country code)

Email address

1. Program completed:
- Registered Nurse
 - Nurse Practitioner
 - Nurse Practitioner-Adult
 - Nurse Practitioner-Neonatal
 - ☐ Nurse Practitioner-Pediatrics
 - Nurse Practitioner-Primary Health Care
 - Other:

2. Name of the program: _____

3. Level of program completed (check one only):
- Post Baccalaureate Certificate
 - Baccalaureate Certificate
 - Master's Degree
 - Post Master's Diploma
 - ☐ Other (please specify): _____

4. Length of program: _____

MM / DD / YYYY MM / DD / YYYY
Date of admission Date of completion

5. Total number of clinical hours required to complete the program: _____

6. Prerequisite for admission to program:

Years _____ Credential _____

7. Was the NP program recognized or approved at the time the applicant completed the program in the jurisdiction in which the program was offered?

Yes No

8. The program was officially recognized or approved by: _____

Name of the Nursing regulatory Body/Board, Licensing/Recognition Governmental Authority or Accrediting Organization

9. Program accreditation by:
- ☐ CCNE ☐ NLNAC (US graduates only)
- ☐ Other _____
- (Name of accrediting / licensing authority)

10. Initial accreditation date: MM / DD / YYYY

11. What is the primary language of your educational institution? _____

Language of instruction: Theory _____

Clinical _____

I hereby certify that to the best of my knowledge this is a true statement of the record of the nursing program of the individual named in Section 1 of this form.

Name (Please print) _____

Title _____

Signature _____ Date (MM/DD/YYYY) _____

Nursing School: Place school seal within the box provided below

Mail to: College of Nurses of Ontario
101 Davenport Rd., Toronto, ON M5R 3P1
Canada

Place Seal Here