Verification of Course Completion and Transcript Request Nurse Practitioner

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

THE STANDARD OF CARE.

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 ______________________

First name ______________________

Applicant's mailing address ______________________

Apt/unit# ______________________

City ______________________

Province/State ______ Postal/Zip Code ______ Country ______

Date of birth (MM/DD/YYYY) ______________________

Gender: ❑ Female ❑ Male

Application number ______________________

Previous Name(s) ______________________

School of Nursing ______________________

Name of Program completed

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

Other ______________________

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

FEB 2021
2021-11

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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 ______________________

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

Address ______________________

Telephone number (include country code)) ______________________

City/Town ______________________

Fax number (include country code) ______________________

Province/State Postal/Zip Code Country ______________________

Email address ______________________

1. Program completed:
   Registered Nurse
   Nurse Practitioner-Adult
   Nurse Practitioner-Paediatrics
   Nurse Practitioner-Primary Health Care
   ❑ Other (please specify): ______________________
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 Date of admission   MM / DD / YYYY 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

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