Summary of Nursing Practice Form

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

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

How to complete this form

Step 1: Fill out the application form.

Step 2: Save the completed form.

Step 3: Attach the saved PDF form to an email message using the subject heading: *SUMMARY OF NURSING PRACTICE*. Send it to enp@cnomail.org

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

Contact information

Last name

First name

Applicant's mailing address

Apt/unit# City

Province/State Postal/Zip Code Country

Date of birth (DD/MMM/YYYY)

Gender: ❑ Female ❑ Male

Telephone number (primary)

E-mail address (primary)

SECTION 2

Summary of Nursing Practice

Have you ever been employed as a NURSE since graduating from your nursing program:

❑ No Please go to Section 3 - Declaration , sign, date and return to CNO

❑ Yes (Please list all nursing employment history below starting with your most recent employer)

If you have additional employers, please make a photocopy of this form and submit it with your application.

Name of employer/agency

Address

City Province/State

Postal/Zip Code Country

Telephone number (include area code)

Fax number (include area code)

Name of contact at employer/agency

E-mail address of contact

Start Date (dd/mmm/yyy) End Date (dd/mmm/yyyy)

Verification of Nursing Practice Form sent to employer (dd/mm/yy):

Employment status:
❑ Full-time
❑ Part-time
❑ Casual

Category:
❑ Registered Nurse
❑ Registered Practical Nurse
❑ Other _____

Position (e.g. Staff nurse)

INCOMPLETE OR MISSING INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION

MAR 2021
2021-29

Summary of Nursing Practice Form continued

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Summary of Nursing Practice

Name of employer/agency

Address

City Province/State

Postal/Zip Code Country

Telephone number (include area code)

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E-mail address of contact

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Category:
❑ Registered Nurse
❑ Registered Practical Nurse
❑ Other _____

Position (e.g. Staff nurse)

Name of employer/agency

Address

City Province/State

Postal/Zip Code Country

Telephone number (include area code)

Fax number (include area code)

Name of contact at employer/agency

E-mail address of contact

Start Date (dd/mmm/yyy) End Date (dd/mmm/yyyy)

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Employment status:
❑ Full-time
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Category:
❑ Registered Nurse
❑ Registered Practical Nurse
❑ Other _____

Position (e.g. Staff nurse)

SECTION 3

Declaration

I _____ hereby certify that I am the person making an
Name (first name last name)

application for a certificate of registration and that all statements are true and complete in every respect. I understand that falsification of information on this application may result in the cancellation of my application for registration or cancellation of any certificate that may be issued.

Applicant's signature:_____ Date: _____

MAR 2021
2021-29

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