BC CN &M British Columbia College of Nurses & Midwives

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Form 5

Confirmation of Psychiatric Nursing Practice Hours

INSTRUCTIONS TO THE APPLICANT:

Complete **SECTION A ONLY** and forward the form to your employer to provide confirmation of your psychiatric nursing practice hours. Use a separate copy of this form for each employer.

SECTION A — Applicant Only

Last name: ______________________________ First name: ______________________________

Middle name: ____________________ Former name(s) if applicable: ______________________________

Date of birth (mm/dd/yy): ____________________ BCCNM ID: ______________________________

Address (Apt/Box/#/Street): ____________________ City/town: ______________________________

Province/State: ______________ Country: __________________ Postal code/zip code: __________

Name of the facility or organization where employed: ______________________________

Address of employer: ______________________________

Name and title of supervisor: ______________________________

I give my consent to you to provide the information requested in Section B of this form directly to the BC College of Nurses and Midwives (BCCNM) and to discuss with the BCCNM any responses to the form.

Date (dd-mm-yyyy): ________________ Applicant's Signature: ______________________________

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INSTRUCTIONS TO THE EMPLOYER:

Please complete the form below and return it **directly** to BCCNM by email at register@bccnm.ca. **(Note: This is not to be sent by the applicant.)**

SECTION B — Employer Only

Job title or position held by this applicant: ______________________________

Job status: ☐ Full-time ☐ Part-time ☐ Casual

Name of the area or unit of practice in which this applicant worked: ______________________________

Date when this applicant started employment (dd-mm-yyyy): ________________

Date when this applicant ended employment (dd-mm-yyyy): ________________

Would you rehire this applicant? ☐ Yes ☐ No

Total psychiatric nursing practice hours worked in last 5 years (most recent first):

Year	Hours
2020	
2019	
2018	
2017	
2016	

SECTION B — Employer Only (cont'd)

Name (please print your complete name):____

Title (please indicate your official title): ____

Phone number (include country code if outside Canada):_____________________________________

Email address: ____

Date (dd-mm-yyyy): ____________________Signature:: _______________________________

IMPORTANT: Please send the completed form directly to BCCNM Registration Services by email at register@bccnm.ca.