

# Employment Reference for Nurse Practitioner Registration

## Instructions

- The referral section must be completed by the applicant's most recent employer or a colleague (nurse practitioner or physician).
- This form should be completed by the employer/colleague reference and returned directly to BCCNM Registration Services at register@bccnm.ca.

## Part A — Personal information (to be completed by applicant)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
Former name(s) if applicable: \_\_\_\_\_ BCCNM ID: \_\_\_\_\_

## Part B — Position information (to be completed by applicant)

Employer name: \_\_\_\_\_  
Position: \_\_\_\_\_ Unit: \_\_\_\_\_  
Date employed (mm/dd/yy) From: \_\_\_\_\_ To: \_\_\_\_\_  
Employment status:  Full-time Hours worked as a nurse practitioner: \_\_\_\_\_  
 Part-time Hours worked as a nurse practitioner: \_\_\_\_\_  
 Casual Hours worked as a nurse practitioner: \_\_\_\_\_  
Employer address (Apt/Box/#/Street): \_\_\_\_\_ City/town: \_\_\_\_\_  
Province/State: \_\_\_\_\_ Country: \_\_\_\_\_ Postal code/zip code: \_\_\_\_\_

## Part C — Employer or colleague reference (to be completed by referee)

Relationship to the applicant:  Employer  
 Colleague

If you are a colleague, what is your role and relationship to the applicant?: \_\_\_\_\_

Describe the population to which nurse practitioner services are/were provided: \_\_\_\_\_

Professional competency:	Satisfactory	Unsatisfactory
Nurse practitioner knowledge and skills	<input type="checkbox"/>	<input type="checkbox"/>
Clinical reasoning and decision-making	<input type="checkbox"/>	<input type="checkbox"/>
Responsibility and accountability	<input type="checkbox"/>	<input type="checkbox"/>
Ethical conduct	<input type="checkbox"/>	<input type="checkbox"/>
Patient and interpersonal relationships	<input type="checkbox"/>	<input type="checkbox"/>

In their practice, does this person have independent diagnosing and prescribing authority?  Yes  No

### Part C— Employer or colleague reference (cont'd)

Do you know of any reason (personal, health, other) why this person may not be fit to engage in the practice of nursing?

- No  
 Yes (specify): \_\_\_\_\_  
\_\_\_\_\_

- Would you re-employ this person?:  Yes  
 Still employed/working with  
 No (specify): \_\_\_\_\_

Is this reference based on:      Personal knowledge?       Yes       No  
   Information on file?       Yes       No

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Part D— Employer or colleague reference information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_

**IMPORTANT**  
Please email the completed reference directly to  
BCCNM Registration Services at [register@bccnm.ca](mailto:register@bccnm.ca)