



CONFIRMATION OF PROGRAM COMPLETION FROM SCHOOL OF NURSING NURSE PRACTITIONER APPLICATION

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SECTION A - APPLICANT

Complete Section A and forward to the school of nursing requesting they complete Section B that verifies the nurse practitioner education program.

SURNAME	GIVEN NAMES	BIRTH/FORMER NAME
DATE OF BIRTH	SCHOOL / INSTITUTE	CITY/PROVINCE
GRADUATION DATE (MM/DD/YY)	SIGNATURE	DATE

SECTION B

To be completed by the designated authority for the nurse practitioner education program. The completed form must be mailed **directly from the designated authority** to the Nova Scotia College of Nursing at the address noted above.

THIS IS TO CERTIFY THAT THE ABOVE-NAMED APPLICANT WAS ADMITTED TO	SCHOOL/INSTITUTE		
DATE STARTED NP PROGRAM	M/D/Y	DATE COMPLETED NP PROGRAM	M/D/Y
CERTIFICATE/DEGREE AWARDED:			
THE PROGRAM OF STUDY WAS FOR THE FOLLOWING CLIENT POPULATION:			
<input type="checkbox"/> FAMILY/ALL AGES	<input type="checkbox"/> NEONATE	<input type="checkbox"/> ADULT	<input type="checkbox"/> PEDIATRIC (CHILD)
CONTROLLED DRUGS AND SUBSTANCES THE APPLICANT COMPLETED AN EDUCATION MODULE RELATED TO THE PRESCRIPTION OF CONTROLLED DRUGS AND SUBSTANCES:		<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE: (ATTACH OFFICIAL CERTIFICATE OF COMPLETION)

AT THE TIME THE APPLICANT COMPLETED THE PROGRAM, IT WAS OFFICIALLY APPROVED BY	REGULATING/ACCREDITING AUTHORITY
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NAME	SIGNATURE	
TITLE	DATE	
MAILING ADDRESS	TELEPHONE NUMBER	EMAIL ADDRESS

SEAL