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FORM A (2)- EVIDENCE OF PRACTICE HOURS

- For initial and reinstatement registration: Evidence of practice hours are required from the employer(s) to satisfy that the minimum practice currency has been met (450 hours of practice in the past two years, or 1125 hours of practice in the past five years in the nursing designation pertinent to the application).

PART A: APPLICANT INFORMATION:

Applicant to complete Part A and forward to the employer for completion of Part B.

If information in Part A is not completed fully by the applicant, the form will not be accepted.

Name: _____ Previous Name(s): _____

Name of Employer/Institution providing the reference: _____

I hereby give my present and /or previous employer consent to provide all information in their possession to the College and Association of Nurses of the Northwest Territories and Nunavut (CANNN) regarding my hours and competency in nursing practice for the sole purpose of assessing eligibility for registration as a Licensed Practical Nurse/ Nurse Practitioner/Registered Nurse and /or Registered Psychiatric Nurse with CANNN.

Signature: _____ Date: _____

Digital or written signatures only



PART B: EMPLOYER REFERENCE

Employer (e.g., Manager, Supervisor, and/or Human Resources Department) to complete Part B and return the form directly to CANNNN (info@cannn.ca).

1. Hours of Nursing Practice within the last 5 years:

Select One:

Date: Year	2025	_____	to	_____	# hours worked	_____	RN	RPN	LPN	NP
		Month		Month						
Date: Year	2024	_____	to	_____	# hours worked	_____	RN	RPN	LPN	NP
		Month		Month						
Date: Year	2023	_____	to	_____	# hours worked	_____	RN	RPN	LPN	NP
		Month		Month						
Date: Year	2022	_____	to	_____	# hours worked	_____	RN	RPN	LPN	NP
		Month		Month						
Date: Year	2021	_____	to	_____	# hours worked	_____	RN	RPN	LPN	NP
		Month		Month						

→ Hours must be submitted separated by year and months in detailed format provided in this form. Hours that are not filled in correctly will not be accepted and may possibly cause a delay in the application process.

2. Additional comments:



I hereby certify the information provided in this reference is true and complete.

Representative completing part B - position/title:

LPN NP RN RPN Other: _____

_____	_____	_____
Print Name in Full	Signature	Title/Position/Designation
_____	_____	_____
Employer/Agency	Phone Number	Date