SASKATCHEWAN RN ASSOCIATION

Saskatchewan Registered
Nurses' Association
2066 Retallack Street
Regina, Saskatchewan
S4T 7X5

Verification of Completion of Nurse Practitioner Education Program

A. To be completed by the applicant and forwarded to the Dean/Program Head/Supervisor of your nurse practitioner program.

Last Name ____________________ Given Name ____________________ Middle Name ______________

Former Name(s) ____

Home Address ____ City ______________

Province/State ______________ Country ______________ Postal/Zip Code ______________

Telephone: Home (___) ______________ Work (___) ______________ Ext ___ Cell (___) ______________

School of Nursing ____

Location ____ Graduation Date ______________

I HEREBY AUTHORIZE YOU TO COMPLETE THE FOLLOWING:

Signature ______________________________ Date ______________________

B. To be completed by the Dean/Program Head/Supervisor of your nurse practitioner program and returned directly to the SRNA.

THIS IS TO CERTIFY THAT ______________________________________ completed the Nurse
Name of Graduate

Practitioner Education Program on ______________________ and has/will graduate from ______________________
Date

____
Nursing Program Location

on ______________________________.
Date

____
Signature

____
Name & Title Date

"RNs and RN(NP)s are leaders in contributing to a healthy population"