Health and Supportive Care Providers Oversight Authority

Verification of Nursing/Midwifery Education Program Completion

Purpose:

This form is intended to confirm that applicants seeking registration with Ontario's Health and Supportive Care Providers Oversight Authority (HSCPOA) through the Recognition of Nurses and Midwives Policy have completed nursing and/or midwifery education that qualifies them to become a nurse and/or midwife in their respective jurisdiction.

Process:

This form must be completed by the educational institution where the qualifying program was completed. By asking the educational institution to complete this form, the applicant is providing consent for this information to be shared with HSCPOA.

This Verification of Education Program Completion form must be submitted to HSCPOA directly by a representative of the educational institution. A completed form submitted by an applicant will not be accepted.

A. Applicant Information – *to be completed by applicant*

First Name	Last Name		
Street Address	City/Town	Province	Postal Code
Home Phone #	Cell Phone #	E-mail Address	

Health and Supportive Care Providers Oversight Authority

B. Education Information – *to be completed by applicant*

Name of School where Nursing/Midwifery education was completed:

Type of institution (e.g. college, university, etc.):

Name of Program completed:

Type of Program:

- ◯ Certificate
- ◯ Diploma
- ◯ Baccalaureate Degree
- ◯ Other (please specify):

_____

Student Number:

Date of Program Completion/Graduation:

I hereby authorize the above-mentioned school to provide the information requested in Section C and any information in its possession to HSCPOA regarding my nursing/midwifery education.

Signature of applicant:

Date (MM/DD/YYYY):

C. Education Institution Information *- to be completed by education program*

Does completion of the nursing and/or midwifery education program noted in **Section B** qualify the graduate to become a nurse and/or midwife in the jurisdiction in which the program was completed?

YES ◯ NO ◯

Comments (if applicable):

The program was officially recognized or approved by:

(Name of Nursing and/or Midwifery Regulatory, Licensing/Recognition Governmental Authority, or Accrediting Organization)

Primary language of your educational institution:

Health and Supportive Care Providers Oversight Authority

Confirmation and Signature from Education Institution:

I affirm that the above information is complete and an accurate representation of the record of the program completed by the individual named in **Section A** of this form.

YES ◯ NO ◯

Full name of Education Institution Representative:

Position/Title of Education Institution Representative:

Email address of Education Institution Representative:

Phone number of Education Institution Representative:

Signature of Education Institution Representative:

Date (MM/DD/YYYY):

The Education Institution is asked to submit this form directly to HSCPOA by e-mail at: registration@hscpoa.com