Supervised Practice Experience Partnership Program (SPEPP)

Completion Form for Employers/Organizations

College of Registered Nurses
of Newfoundland and Labrador
1033 Topsail Road, Mount Pears, NL A1N 5E9
https://crnnl.ca

Telephone: 709 753 6040
Toll-free (Canada): 1 800 563 3200
Fax: 709 753 4940 Email: registration@crnnl.ca

Instructions

This form must be completed by the employer/organization after the applicant has completed a minimum of 450 hours for RNs or 900 hours for NPs under supervision.

When SPEPP is complete, please compete and email this form to registration@crnnl.ca using the subject heading SPEPP COMPLETION FORM FOR ORGANIZATIONS.

SECTION 1 – APPLICANT INFORMATION

First name ______________________

Email Address ______________________

Last name ______________________

Registration number: ______________________

Category of Registration: ☐ Registered Nurse ☐ Nurse Practitioner

APPLICANT CONSENT

In order to verify my evidence of practice requirements, the College is requesting that the organization provide information with respect to my supervised practice experience. I hereby give this organization my consent to provide any and all information to the College regarding my supervised practice experience. This shall constitute your legal authority to provide the information and any other information which the College shall request which may, in any way, be relevant to my application.

Signature ______________________

Telephone Number ______________________

SECTION 2 – EMPLOYER/ORGANIZATION INFORMATION

Site name ______________________

Telephone Number ______________________

Street Address ______________________

Primary Contact first name ______________________

City ______________________

Primary contact last name ______________________

Postal code ______________________

Primary contact email address ______________________

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IEN OR RE-ENTRY NURSE SUPERVISED PRACTICE EXPERIENCE

1. Date of supervised practice experience

Start date (DD/MM/YYYY) ____________________ Completion date (DD/MM/YYYY) ____________________

2. Total hours completed: ____________________

3. Did the applicant complete a minimum of 450 for RN or 900 hours for NP?

Yes ☐

No ☐

If no, please explain why.

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4. Was the applicant successful in meeting all the competency requirements?

Yes ☐

No ☐

If no, please include the completed SPEPP Initial and Final Assessment Forms to registration@crnnl.ca.

Name: ____________________ Signature: ____________________

Date: ____________________