

**STATEMENT OF POST-SECONDARY
TEACHING SERVICE**

Surname First Name Initial Previous Name (if applicable)

Social Insurance Number _____

INSTITUTION IN WHICH THE TEACHING SERVICE WAS COMPLETED:

Institution _____

Address _____

Postal Code/Zip Code _____ Tel. No. _____ Fax No. _____

Description of the Teaching position held by the above named teacher: _____

***The following section is to be completed by an authorized official of the Institution and returned directly to:

Teacher Certification
Department of Education
P.O. Box 8700, St. John's, NL A1B 4J6
Or Fax to (709) 729-5026

Do not return this form to the teacher

Please provide the requested information below for each school year the above named teacher has taught in this institution. The information must include the beginning and end dates of employment; teaching status; the number of days that define a full normal year of teaching in this institution; and the sick leave used each year. Photocopy this form if additional pages are required.

Year taught dd/mm/yy	Status: F/T or P/T (%)	No. of full time days or F/T equivalent days taught	How many days comprise a full time teaching year?	Number of sick leave days used in each year?	Dept. of Education use only	
					Code	Days Credited
__/__/__ to __/__/__						
__/__/__ to __/__/__						
__/__/__ to __/__/__						
__/__/__ to __/__/__						
__/__/__ to __/__/__						
__/__/__ to __/__/__						
__/__/__ to __/__/__						

I certify the above information is a true and accurate record of *teaching service* of the above named teacher.

Authorized Official (print and signature)

Position

Date

