Government of Newfoundland and Labrador
Department of Education and Early Childhood Development

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 and Early Childhood Development
PO Box 8700, St. John's NL Canada 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
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I certify the above information is a true and accurate statement of *teaching service* for the above-named teacher.

Authorized Official (print and signature) ____ **Email Address** ____ **Position** ____ **Date** ____