



STATEMENT OF M/34 TEACHING SERVICE

SECTION I: TO BE COMPLETED BY TEACHER

Surname _____ First Name _____ Initial _____ Previous Name (if applicable) _____

Social Insurance Number: _____

Email Address: _____

INSTITUTION IN WHICH THE TEACHING SERVICE WAS COMPLETED:

Institution: _____

Address: _____ Country _____

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

Description of the teaching position held by the above-named teacher: _____

SECTION II: 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 (Canada) or email teachercertification@gov.nl.ca

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; and the number of days that define a full, normal year of teaching in this institution. Include the sick leave used each year if service was completed within the province. Photocopy this form if additional pages are required.

Academic Year taught DD/MM/YY	Status: F/T or P/T (%)	Number of days that comprise a full-time teaching year in your school	Number of full- time days this teacher taught.	Number of sick leave days used in each year *NL service only	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 _____