Government of Newfoundland and Labrador
Department of Education

STATEMENT OF POST-SECONDARY 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: _____

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 OFFICAL OF 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; 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.

Academic Year taught DD/MM/YY	Status: F/T or P/T (%)	No. of courses taught per year	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**