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: _____ _____ _____

Tel No: _____

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 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**