

CONFIRMATION OF SPONSORSHIP FORM

Your First Name: _____

Your Last Name: _____

Your Job Title: _____

Your Zone:

Please select from the following:

- Provincial Central Zone Eastern Zone Northern Zone Western Zone
 IWK Other: _____

Your Phone Number: _____

Your Email Address: _____

Sponsored Learner's First Name: _____

Sponsored Learner's Last Name: _____

Name of Program:

Please select from the options:

- Cancer Systemic Therapy Certification Course
 Critical Care Nursing Program
 Critical Care Paramedic Program
 Emergency Nursing Program
 Foundations in Nephrology Nursing Program
 Family Practice Nursing Program
 High Acuity Nursing Program
 Interprofessional Simulation Facilitation Course
 Mental Health and Addictions Nursing Specialty Program
 Neonatal Education Program
 Pediatric Education Program Perinatal Orientation Education Program
 Perioperative Nursing Program
 Suicide Risk Assessment & Intervention Interprofessional Program

Program Study Option: Full time Part time

Cost Centre for Payment of Course Fees (please enter N/A if you are sponsoring the learner clinically but not financially): _____

I confirm that I am sponsoring this learner to participate in this program.

Yes