**VERIFICATION OF SERVICE FORM**

**CANDIDATE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you have been employed by more than one Health Service Provider/Employing Authority, you must complete and submit a separate Verification of Service Form for each Employer. This form must be completed by the relevant HR/Payroll Dept. or by the Director of Nursing. An employer may not include periods of previous employment with another Health Service Provider/Employing Authority, when completing the Form.**

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| **Title of post held / Grade (i.e. RPN/ RCN/RNID/RGN/RM)** | **Name of Employer** | **Please state Unit and Work Location (e.g. Geriatric, Theatre, A & E, Connolly Hospital Blanchardstown)** | **Date employed from**  **(00/00/0000)** | **Date employed to**  **(00/00/0000)** | **Length of time (please enter number of WEEKS worked)** | **Please indicate if employed in a full-time or part-time capacity** | **Hours Worked per week** | **If part-time, please state average hours worked per week (weekly average over a 4 week roster)** |
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Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Official Stamp

On behalf of Health Service Provider/Employing Authority PRINT NAME

Position in Organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Tel. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Form **must be stamped** if completed by the relevant HR/Payroll Dept**., failure to do so will deem it invalid**. Where completed by a **Director of Nursing**, the Form will be accepted without an official stamp. National Recruitment Service may contact the Director of Nursing to verify completed Form.