

CO-OPERATIVE LEARNING EXPERIENCE PROGRAM – EMPLOYER REPORT FORM

Year _____

Requested by: _____ for reimbursement of Co-operative Learning Experience costs:
 (name of organization/facility)

STUDENT'S NAME	START DATE	END DATE	TOTAL # HOURS WORKED	AMOUNT PAID (hours worked X hourly rate)	OVERTIME/ VACATION PAY/ OTHER	TOTAL COSTS
					TOTAL COSTS	

Employer verification: I certify that the amounts in this claim meet the terms and conditions as outlined in the DoH Policy *Nova Scotia's Nursing Strategy Co-operative Learning Experience*.

Name (please print): _____ Signature: _____ Date: _____

DOH USE ONLY	
Date Received:	Authorized Signature: