SickKids LEARNING INSTITUTE

Building Partnerships in Learning

Nursing Visitor Application Form

Section A: Personal Information

Name

Position

Address

Hospital/ Agency Name and Address

Phone Number

Area of Practice

E-mail

Supervisor/ Manager's Name

Supervisor/ Manager's E-mail

For visitors requesting practice experience
please provide your certificate of registration number and jurisdiction where registration was issued

SickKids
LEARNING
INSTITUTE

Section B: Visit Information

Expected date of visit _____ to _____

Contact at SickKids (if known) _____

Why do you wish to visit the Hospital for Sick Children? _____

What are some learning objectives you have identified? _____

What prior learning/experience have you had in relation to thse objectives? _____

how would you prefer to meet your objectives?

- ☐ Observation of Clinical Practice
- ☐ Practice Experience
- ☐ Information Interview

It is understood that during your visit you may have access to confidential information. Your Signature below indicates that you recognize that you are in a position of trust with The Hospital for Sick Children and agree to maintain confidentiality at all times

Signature _____ Date _____

- ☐ Current resume/ CV attached
- ☐ Application Payment Form
- ☐ Supervisor/Manager's Letter of Support