

POST-MASTER'S WORK CONFIRMATION FORM

Please complete this form and submit directly to the College by mail, fax, or e-mail.

| Name of Candidate: | |
|---------------------------------|-----------|
| Name of Supervisor: | |
| Supervisor's Regulatory Board: | |
| Job Title: | |
| | |
| Organization Name: | |
| Responsibilities: | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| Start Date: | End Date: |
| Total Hours Completed: | |
| Additional Comments (Optional): | |
| | |
| | |
| | |
| | |
| | |
| | |
| Signature | |
| Date: | |