**CERTIFICATION FROM HOSPITAL FORM**

**Instruction:**

The Supervisor shall accomplish this form, and to be attested by the Chief Nurse/Nursing Director. The perioperative nurse shall submit the duly accomplished form to ORNAP for his/her membership application.

This is to certify that the following are bona fide Registered Nurses of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_located at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Name of Hospital/ Institution) (Address of Hospital/ Institution)

|  |  |  |
| --- | --- | --- |
|  | **Name of Nurses**  *Last Name, First Name, Middle Initial* | **Area of Assignment** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |

This certification is issued upon the request of the above Registered Nurse/s as one of the requirements in ORNAP Membership application.

Prepared by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisors’ signature over printed name/ Date signed

Attested by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Nurse/Nursing Director’s signature over printed name/ Date signed