WORK EXPERIENCE FORM

FCIP
Leadership Defined.

Name:

Member Number:

Date:

Insurance Institute of Canada
18 King St. E., 6th Floor
Toronto, ON M5C 1C4
Phone: 416-362-8586
Fax: 416-362-2692
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Employment Experience

Current and Previous Positions (list in order of most recent)

Employer:

Job Title:

Duties and Responsibilities:

Start Date:

End Date:

Type of Employment:

Direct Reports:

Employer:

Job Title:

Duties and Responsibilities:

Start Date:

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Direct Reports:

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References

A person/persons who can verify the accuracy of the information on this form. References may or may not be contacted.

Name	Relationship	Phone Number	E-mail Address

Declaration

I am providing the information on this form to confirm that I meet the relevent work experience requirements of the Insurance Institute's FCIP Program.

I confirm that all information on this form and in any supporting documentation is accurate and fairly represents my experience.

☐ By clicking this box and submitting the form, I agree with the declaration stated above.

RESET SUBMIT