Excelsior College School of Nursing

VERIFICATION OF HEALTH CARE EXPERIENCE

☐ I am applying for admission ☐ I am submitting for approval for Phase III

All applicants to the associate degree nursing program and all students enrolled in the program are required to sign and submit this document as part of the admissions process and for approval to Phase III. By signing this document, you acknowledge the program is designed for individuals with a current nursing-related health care practice. **Supervisor*** verification is necessary to confirm the applicant or student:

1. is employed in a setting that requires LPN/LVN, paramedic, or approved military occupation as a condition of employment;
2. includes job responsibilities for direct, hands-on patient care (common nursing skills; observation of RN-level activities); and
3. has completed at least 200 hours of employment and is working in this practice setting within one year prior to signing this form.

Applicant/Student Information

Name _____ Email _____

Address _____ Phone _____
Street

_____
City State Zip Code

Applicant/Student Work Experience

Title of current position _____

Name of organization _____

Address _____
Street

_____
City State Zip Code

Credential (select one):
- ☐ LPN/LVN
- ☐ Paramedic
- ☐ Military (Please specify occupation title)

_____

Hours worked as an LPN/LVN, paramedic, or military occupation within previous year _____

Provide a detailed description of the direct, hands-on patient care you provide to patients:

Applicant/Student Signature

By my signature below, I acknowledge I am applying for admission or I am enrolled in a program designed for students with nursing-related health care experience. I recognize I must be working in at least a minimal capacity during enrollment in order to apply new knowledge to the current health care system. I certify that the above information is true and correct, and that any false, deceptive, or misleading statements shall subject me to academic dismissal from the College.

_____ _____
Signature Date

*Supervisor is defined as one who holds health care credentials and evaluates your clinical practice.

Supervisor* Signature

By my signature below, I confirm the above-named student has completed at least 200 hours of employment and is working in this practice setting within one year prior to the date below. The information above accurately describes the experience of the student within this organization.

_____ _____
Signature Date

_____
Supervisor's Name, Title (please print)

_____
Supervisor's Health Care Credential(s) (please print)

_____
Phone Number Email

This form expires three (3) months from the date of your supervisor's signature.