Excelsior University School of Nursing

Verification of Health Care Experience (Associate in Applied Science in Nursing)

☐ **Applying for admission to the Associate in Applied Science in Nursing program** ☐ **Submitting for approval for NUR 217 requirement**

All applicants to the Associate in Applied Science in Nursing program are required to sign and submit this document as part of the admissions process, and all students enrolled in the program must sign and submit it before course approval for NUR 217. By signing this document, you acknowledge that the program is designed for LPNs, LVNs, paramedics, and certain classifications of active duty military, National Guard, or Reserves within specific military occupations with equivalent scope of practice to LPN/LVN or paramedic.
Supervisor* verification is necessary to confirm the applicant or student:

1. is employed in a setting that requires LPN/LVN, paramedic, or a specific military occupation that is equivalent to the scope of practice of LPN/LVN or paramedic as a condition of employment;
2. includes job responsibilities for direct, hands-on patient care (common nursing skills; observation of RN-level activities) or indirect patient care (manager/supervisor, quality improvement, collaborating with the healthcare team); 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

Current Position _____

Organization _____ **Address** _____
Street, City, State, Zip Code

Hours worked as an LPN/LVN, Paramedic, or Military Equivalent within the previous year _____

Provide a detailed description of the patient care you provide to patients:

APPLICANT/STUDENT INFORMATION

- Review each skill listed and indicate your level of experience based on actual clinical or field performance.
- Only select levels that reflect direct experience, not classroom or simulation learning alone.
- If a skill is not applicable to your role or scope of practice, select N/A (Not Applicable).
- Ensure all skills are checked prior to submission.

DEFINITIONS OF COMPETENCY LEVELS

- **Novice** *(Observed Only)*: The applicant/student has observed the skill but has not performed it independently.
- **Advanced Beginner** *(With Supervision)*: The applicant/student has performed the skill with guidance or supervision.
- **Competent** *(Performs Independently)*: The applicant/student can perform the skill safely without direct supervision within their scope of practice.
- **Proficient** *(Consistent & Confident)*: The applicant/student performs the skill consistently, accurately, and with confidence in routine situations.
- **Not Applicable:** The skill is not part of the applicant/student's role, training, or scope of practice.

Skill	Novice	Advanced Beginner	Competent	Proficient	Not Applicable
Vital Signs	☐	☐	☐	☐	☐
Head-to-Toe Physical Assessment	☐	☐	☐	☐	☐
Health History/Patient Interview	☐	☐	☐	☐	☐
Infection Control (PPE, Hand Hygiene)	☐	☐	☐	☐	☐
Oral Medication Administration	☐	☐	☐	☐	☐
Injectable Medication (IM/SubQ)	☐	☐	☐	☐	☐
IV Medication Administration (if applicable)	☐	☐	☐	☐	☐
Wound Care/Dressing Changes	☐	☐	☐	☐	☐
Urinary Catheterization	☐	☐	☐	☐	☐
Patient Mobility/Transfers	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐
Documentation	☐	☐	☐	☐	☐
Basic Emergency Response (CPR, escalation)	☐	☐	☐	☐	☐

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 Excelsior University.

Signature _____ Date _____

SUPERVISOR* SIGNATURE

By my signature below, I verify that the above-named student has completed at least 200 hours of employment within one year prior to the date below in the practice setting indicated. I further confirm that the information provided accurately reflects the student's clinical experience within this organization.

I have reviewed the Skills Checklist and verified that the selected levels are consistent with the student's typical performance, based on direct observation or knowledge of their clinical practice.

Signature _____ Date _____

Supervisor's Name, Title (please print) _____ Supervisor's Health Care Credential(s) _____

Phone Number _____ Email _____

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

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