Excelsior College School of Nursing

VERIFICATION OF HEALTH CARE EXPERIENCE

☐ I am applying for admission ☐ I am submitting verification for FCCA® eligibility

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 eligibility criteria for the Focused Clinical Competencies Assessment® (FCCA) and 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 currently credentialed as an LPN/LVN, a paramedic, or a specific military medical classification;
2. is employed in a setting that requires direct patient care, including performance or opportunity for observation of common nursing psychomotor skills; and
3. has completed at least 200 hours of employment in this practice setting within the calendar 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 in previous year _____ _____

Brief description of role responsibilities, including patient care:

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.

_____ _____
Signature Date

Supervisor* Signature

By my signature below, I confirm the above-named student has completed at least 200 hours of employment 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 & Health Care Credential(s) (please print)

_____
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.