VERIFICATION OF DIRECT PATIENT CARE EXPERIENCE

College of Eastern Idaho
Associate Degree Nursing Program

Student Authorization:

I hereby give permission for the release of information to the Associate Degree Nursing Program at College of Eastern Idaho:

Applicant Name (printed): _____

Signature: _____ Date: _____

Employer Verification:

Must be completed by HR or employer. Please complete the following information below regarding this employee. After completion, please return this form to the employee.

Facility Name: _____

Position held by Applicant: _____

Unit worked/description of unit: _____

Dates of employment: _____

Total number of Hours worked in direct patient care at this facility in the preceding 3 years: _____

Name and Position of individual completing this form: _____

_____

Signature: _____ Phone number: _____

Date: _____