Excelsior University School of Nursing

Verification of Health Care Experience (Associate Degree in Nursing)

☐ **Applying for admission to the Associate Degree program** ☐ **Submitting for approval for the NUR 250 requirement**

All applicants to the associate degree nursing program are required to sign and submit this document as part of the admissions process, and all students enrolled in the program are required to sign and submit it for approval for NUR 250. 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) 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

Credential (select one): ☐ **LPN/LVN** ☐ **Paramedic** ☐ **Military** (specify occupation title): _____

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

Provide a detailed description of the 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 Excelsior University.

_____ _____
Signature Date

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)

_____
Phone Number Email

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

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