El Camino College

NURSING DEPARTMENT WORK VERIFICATION FORM

Licensed or certificated healthcare worker applying for admission consideration to the El Camino College Associate Degree Nursing program must have their immediate work supervisor complete this form. Once completed, please return to the El Camino College Nursing Department along with your application for admission consideration.

Applicant's Name_____ **Applicant's Student ID #** _____

Name of institution where I work _____

Job Title _____

Start Date _____ **End Date** _____ **of employment in this position**

(*Indicate present if you are still employed at the facility for end date*)

Employment Status ☐ **Full-time** ☐ Part-time

Number of hours worked per week _____

I work in an (check one) ☐ **Acute Care Setting** ☐ **Sub-Acute Care Setting** **OR**

☐ **Other** (*Please specify*) _____

Job responsibilities:

☐ **Copy of current/valid license or certificate is attached** to my application

My signature below indicates that the above information provided on this form is true

Applicant's Signature_____

This section is to be completed by the person verifying employment

Supervisor's Name (*Please print*) _____

Supervisor's Title _____

Contact Phone # _____

My signature below indicates that I am in agreement with the above information on this form

Supervisor's Signature _____

Date _____