VERIFICATION OF DIRECT PATIENT CARE EXPERIENCE

College of Eastern Idaho

Student Authorization:

I hereby give permission for the release of information to the College of Eastern Idaho's Nursing Program.

Employee/Student Name (printed): _____

Signature: _____ Date: _____

CEI Student #: _____

Employer Verification:

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

Facility Name: _____

Position held by Employee: _____

Unit Worked/description of unit: _____

Dates of Employment: _____

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

Name and Title of individual completing this form: _____

Signature: _____ Date: _____

Phone Number: _____