

## Registered Nursing

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### 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: \_\_\_\_\_