
HEALTH CARE EMPLOYMENT WITH LICENSE OR CERTIFICATE**TO BE COMPLETED BY APPLICANT**

I would like to request your assistance in providing verification of my employment with your organization. I have applied for acceptance to the Spokane Community College Program. This form is necessary to complete my application to the Registered Nurse Program at Spokane Community College. My signature below authorizes my former or current employers to provide the information requested below.

Student's Name (typed): _____
Last First Middle

Student's Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYMENT SUPERVISOR

(Handwritten employee forms will be accepted)

Student Name: _____
(Last) (First) (Middle)

Supervisor's Name: _____ Date: _____

Facility / Business Name: _____

Address: _____
Street or PO box City State ZIP Code

Phone: _____
###-###-####

Position or title applicant held under active license while employed with your organization:

Primary duties or responsibilities: _____

Start and end dates of employment worked under a State and/or Federal license or certification within the last five years:

Number of hours worked under the license or certification within the last five years. Employment dates must fall within licensure period (include a copy of license):

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and accurate.

Supervisor's Name (Print): _____

Supervisor's Signature: _____ Date: _____