



# NURSING PROGRAM APPLICATION FORM

## 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. This form is necessary to complete my application to the Practical Nursing 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

*(This section may be handwritten by the supervisor)*

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:

Total 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: \_\_\_\_\_  
Street or PO box City State ZIP Code