EASTERN FLORIDA STATE COLLEGE

VERIFICATION OF HEALTH-RELATED EXPERIENCE

The Nursing / Health Science applicant listed below has applied for our
(print program name) ___________________________________________ program.

(Applicant) Last Name________________________ First Name____________________ M.I.____

has been employed/volunteered with (name of business)________________________________________

________________________

from (month/day/year)___/___/____ to (month/day/year)___/___/____,

on an average of _______ hours per week as a (an) __________________________________________

We would appreciate an attached statement concerning this applicant and give a general description of
his/her duties while under your supervision/employment.

________________________

SIGNATURE OF SUPERVISOR

DATE

________________________

SUPERVISOR’S NAME (PRINT)

SUPERVISOR’S TITLE

________________________

BUSINESS STREET ADDRESS

BUSINESS PHONE

________________________

CITY STATE ZIP CODE

PLEASE RETURN BY -

Mail: Eastern Florida State College
ATTN: Nursing & Health Sciences Admissions
1519 Clearlake Road Cocoa, FL 32922
Fax: 321-433-7579
Email: healthscience@easternflorida.edu

*This form must be received by the application deadline of the applicant’s intended program.*
If you have any questions, please call 321-433-7575