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
Building 15, Room 101
3865 North Wickham Road Melbourne, FL 32935

OR

Eastern Florida State College
ATTN: Nursing & Health Sciences Admissions
Building 11, Room 228
1519 Clearlake Road Cocoa, FL 32922

OR

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