PCC Nursing Program

Healthcare Experience Documentation Form - Part I

Applicant Name:	Applicant Student ID Number: G0

Part I: To Be Completed by The Applicant		
Check off the box that reflects your healthcare experience hours:	☐	1000 – 1999 hours = **4 points**
	☐	240 – 999 hours = **2 points**

- Applicants may earn up to 4 points for healthcare experience hours completed in the last 10 years.
- Healthcare experience hours will be counted through the end of fall term (December 15, 2024) prior to the application deadline. Healthcare experience points will not be awarded if this form is incomplete or if supporting documentation of paid or unpaid work experience hours is missing.
- Paid or unpaid international or domestic hours of healthcare experience may be used. Examples of approved facilities include: medical setting, home care, community health, health education, or military.
- All supporting documents must be translated to English and be included/uploaded in the documents section in the NCAS application.
- Failure to upload supporting documentation will affect consideration for experience points.
- **All required documentation must be uploaded to the applicants NCAS application by the February 17, 2025. Documentation submitted after that date will not be considered.**
- By signing below, I certify that my information is complete and understand that providing false information on this form will result in nullification of application and/or dismissal from the program.
- I understand that I am required to submit both pages of this form for my experience to be considered.

Applicant Signature: _____ **Date:** _____/_____/_____

Both pages of this form must be uploaded to the documents section in the NCAS Application.

PCC Nursing Program

Healthcare Experience Documentation Form - Part II

Part II: To Be Completed by The Supervisor or Human Resource Representative			
Supervisor or Human Resources Representative Contact Information:			
Organization or Business Name:			
Organization or Business Address:			
Supervisor Name or HR Representative Name:			
Supervisor or HR Representative Title:			
Primary Contact Phone:			
Primary Contact Email:			
Applicant's position title at your facility:			
Dates of employment/service:	Begin Date:	End Date:	
Hours completed though December 15, 2024:	Total Hours:		
Is this position a paid employee? (Please check one)		□ Yes	□ No
Are credentials required for this position? (Please check one)		□ Yes	□ No
If YES, specify the credential type:			
Provide a brief description below of the position/service performed **OR** attach a detailed job description:			

I verify the above-identified applicant's work experience and hours are complete and true. PCC reserves the right to contact anyone listed on this form to verify that this information. **Forms will not be accepted without a valid supervisor or HR representative signature.**

Supervisor or HR Representative Signature: _____ **Date:** ___/___/_____

Both pages of this form must be uploaded to the documents section in the NCAS Application.