Portland Community College

Portland Community College Radiography Program
Healthcare Experience Verification Form

Applicant Name: _____

Applicant Student ID Number: _____

Healthcare Experience Hours (Select One):

- ☐ **25pts:** 2,000 or more hours
- ☐ **20pts:** 1,000 – 1,999 hours
- ☐ **15pts:** 500 – 999 hours

To Be Completed by a Supervisor or Human Resource Representative:

Organization/Business Name: _____

Organization/Business Address: _____

Supervisor/HR Representative:

Name: _____

Title: _____

Phone Number: _____

Email: _____

Applicant's:

Position Title at Facility (please attach a position description): _____

Dates of Employment/Service:

Begin Date: _____

End Date (if still employed, write "Current"): _____

Total Hours Completed through March 21, 2027: _____

Is this a paid position? _____

Are credentials required for this position (if so, what credential)? _____

By signing below, 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 this information. **Forms will not be accepted if incomplete and must have a valid supervisor or HR representative signature.**

Supervisor/HR Representative Signature: _____

Date: _____

This form must be uploaded to the documents section in the AHCAS application for points.