



## PCC Nursing Program Healthcare Experience Documentation Form

Applicant Name:	Applicant Student ID Number: <b>G0</b>
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### Part I: To Be Completed by The Applicant

Check off the box that reflects your healthcare experience hours completed through December 14, 2025:	<input type="checkbox"/>	1000+ hours = <b>4 points</b>
	<input type="checkbox"/>	240 – 999 hours = <b>2 points</b>

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Part II: To Be Completed by The Supervisor or Human Resource Representative

Organization or Business Name:		
Organization or Business Address:		
Supervisor/HR Representative Name & 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 14, 2025:	Total Hours:	
Is this position a paid employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are credentials required for this position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, specify the credential type:		
Please attach a brief description of the position/work 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 this information. **Forms will not be accepted without a valid supervisor or HR representative signature.**

Supervisor or HR Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_