COLLEGE OF SOUTHERN NEVADA
HEALTH CARE EXPERIENCE

For which **semester** and **year** are you applying?

For which program are you applying? Check: □ Surgical Technology Program

Applicant name (please print): ___________________________NSHE ID#:________________

I give my permission to release the requested information to the CSN Surgical Technology Program.

Signature:____Date:_______________________

Once this form has been completed and signed by employer, the applicant must submit with the completion packet to:

Limited-Entry Admissions, Room WCK 216
College of Southern Nevada
6375 West Charleston Boulevard
Las Vegas, NV 89146

Employer Name:____

Address:____

Phone:_____________________________________

Name and title of person completing form (please print):________________________________

Provide a brief description of the agency (e.g. hospital, nursing home, home health, etc.):

Provide a brief description of the responsibilities of the applicant:

Applicant employed from:____________________to:________________________

□ Full-time employment or □ Part-time employment

Would you rehire this person?

Please comment on the strengths and weaknesses of the applicant:

Signature:____Date:____________________

3/29/2016