COMMUNITY COLLEGE
OF RHODE ISLAND

Office of Nursing

Employment Verification Form

Applicant Information – To be completed by APPLICANT

CCRI ID # _____ LPN License # _____ Exp _____

Last Name _____ First Name _____ MI ____

Phone Number _____ Email Address _____

Employer Information – To be completed by APPLICANT

Agency Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Applicant: Once you have finished these two sections, give this form to your supervisor.

Supervisor: Please complete the section below, then email this form to:

Level I Chair, Nursing Department
Michelle Bull
mbull@ccri.edu

Applicant's LPN Work History – To be completed by NURSING SUPERVISOR

LPN Start Date at your agency _____ LPN End Date at your agency _____

# of hours applicant worked for you as LPN: >500 ☐ <1000 ☐ >1000 ☐ >1500 ☐

Types of Experience _ (e.g., direct patient care; leadership/management) _____

_____

Please print Supervisor's Name _____

Phone Number _____ Email Address _____

Supervisor's Signature _____ Date _____