Medical Certification Bridge Program Applicant Certification of Work Experience Form PLEASE PRINT CLEARLY. Return this form with a copy of your non-expired valid photo ID to Experienceevaluationdept@gmail.com

The information herein will be used to determine qualifications of certification applicants.

Discipline/Certification for which application is being made _____

Name of Individual seeking certification _____

Home Address _____

Home telephone no. (_____)_____ Please list all medical/ healthcare certifications or licenses you currently have or had. _____

Please provide the following information as completely and accurately as possible. Any misrepresentation may result in denial or revocation of certification.

DATES WORK HISTORY

_____ _____

from Employer

_____

_____ Address

to _____ (_____)_____

City Zip Work phone

_____

Work description

DATES WORK HISTORY

_____ _____

from Employer

_____

_____ Address

to _____ (_____)_____

City Zip Work phone

_____

Work description

additional information must be entered on page 3

DATES | WORK HISTORY

from _____ Employer _____

Address _____

to _____ ( ) _____

City Zip Work phone

Work description _____

DATES | WORK HISTORY

from _____ Employer _____

Address _____

to _____ ( ) _____

City Zip Work phone

Work description _____

additional information must be entered on page 3

I hereby certify that the above is a true representation of my work history. Any misrepresentation may result in denial or revocation of certification.

_____ _____

Signature date

I hereby certify that the above is a true representation of my work history. Any misrepresentation may result in denial or revocation of certification.

Signature _____ date _____

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The evaluation department verifies this applicant's information has been verified

Information verified Yes / No (Initial/Date) _____

Application approved Yes / No (Initial/Date) _____

Application denied Yes / No (Initial/Date) _____