

Verification of Work in Healthcare

I hereby authorize Klamath Community College to contact the organization (s) listed below for the purpose of verifying my work hours.

Student Information

Student Name: _____

Job Title: _____

Dates of Employment: From _____ To _____

Employer Information

Facility/Organization Name: _____

Supervisor Name: _____

Phone Number: _____

Email Address: _____

Klamath Community College Nursing Program (second reference if required)

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Job Title: _____

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Email Address: _____

Student Signature _____ Date _____