

# 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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## **Student Information**

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Job Title: \_\_\_\_\_

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## **Employer Information**

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Supervisor Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Student Signature \_\_\_\_\_ Date

\_\_\_\_\_