



Registered Nurse AAS Program
Direct Patient Care Experience Verification Form
 (Optional qualification for admission)

Applicants who meet all application requirements will be given additional consideration if they have **at least one year** of qualified direct patient care experience. Although not an admission requirement, this optional experience can improve their chances of selection.

What is Direct Patient Care Experience?

Direct Patient Care Experience involves providing hands-on assisting and care to patients in healthcare settings. This type of experience requires direct interaction with patients and often includes tasks related to their physical or emotional well-being. It typically takes place in settings like hospitals, clinics, nursing homes, or home care environments.

Common Roles (Examples):

- Certified Nursing Assistant (CNA)
- Emergency Medical Technician (EMT)
- Home Health Aide
- Medical Assistant (MA)
- Patient Care Technician (PCT)
- Respiratory Therapist
- Surgical Technologist

If you have **at least one year** of direct patient care experience, complete this verification form and upload it to your RN application in the designated section. Ensure all fields are filled out completely to be considered.

| PART I: TO BE COMPLETED BY APPLICANT | | | |
|--|-------------------|--------------------|--|
| Applicant's Full Name: | | ctcLink ID number: | |
| Email Address: | | Phone Number: | |
| Experience Details: | | | |
| Institution/organization Name: | | Job Title: | |
| Dates of Service: | Start Date: | End Date: | |
| Supervisor's Name: | | Job Title: | |
| Supervisor's Email Address: | | Phone Number: | |
| Brief Description of Duties Performed: | | | |
| | | | |
| PART II: TO BE COMPLETED BY SUPERVISOR | | | |
| I hereby confirm that the above-named applicant has completed the service as described. | | | |
| Printed Name: | Signature: | Date: | |
| PART III: APPLICANT'S ACKNOWLEDGEMENT | | | |
| I hereby affirm that the information provided in this form is accurate and true to the best of my knowledge. | | | |
| Printed Name: | Signature: | Date: | |

Questions? Contact Nursing Admissions, nursingapp@highline.edu.