

CCC Nursing Program Healthcare Work Experience Documentation Form-Part 2

PART 2: To be completed by the supervisor or human resource representative			
Supervisor/Human Resources Representative contact information:			
Applicant Name & Title at your facility:			
Organization or Business Name & Address:			
Supervisor Name/HR Representative Name:			
Supervisor/HR Representative Title:			
Primary Contact Phone:			
Email Address:			
Dates of Employment/Service:	Begin Date:	End Date:	
Hours completed through January 22, 2027:	Total Hours:	-OR-	Average Weekly Hours:
Is this a paid employee position? (Please check one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is a certification or licensure required for this position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please specify the license or certification type:			
Please provide a brief description of the position/service performed OR provide a detailed position description to be uploaded to the applicants NCAS application:			

I verify the above-identified applicant’s work experience and hours completed. The accrued work experience hours have been calculated through **January 22, 2027**. CCC reserves the right to contact anyone listed on this form to verify that this information is true and correct. All required documentation must be uploaded to the applicant’s NCAS online application by 8:59pm PST (11:59pm EST) on February 16, 2027. Documentation submitted after that date and time will not be considered. **Forms will not be accepted without a valid supervisor signature.**

Supervisor/HR Representative Signature: _____ **Date:** _____

Note to applicant: Providing false information on this form will result in nullification of application and/or dismissal from the program.

Both pages of this completed form must be uploaded to your NCAS Application.