



**COCC Nursing Program**  
**Healthcare Experience Documentation Form**

<b>Applicant Name:</b>	<b>Applicant Student ID Number:</b> 820-
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**Part I: To Be Completed by The Applicant**

<b>Check off the box that reflects your healthcare experience hours:</b>	<input type="checkbox"/>	200 or more hours = <b>5 points</b>
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- Applicants may earn five points for qualified healthcare experience.
- Healthcare work experience hours must have been completed in the time period of June 1, 2025 to prior to the application deadline of May 1, 2026. Healthcare experience points will not be awarded if this form is incomplete or if supporting documentation of paid or unpaid work experience hours is missing.
- Paid or unpaid international or domestic hours of healthcare experience may be used.
- All pages of this document and any additional supporting documents must uploaded in the documents section in the COCC Nursing application.
- Failure to upload this form or supporting documentation will affect consideration for experience points.
- **All required documentation must be uploaded to the application by May 1, 2026. Documentation submitted after that date will not be considered.**
- By signing below, I certify that my information is complete and understand that providing false information on this form will result in nullification of application and/or dismissal from the program.
- I understand that I am required to submit all pages of this form for my experience to be considered.

Acceptable Healthcare Experience is defined by licensed or certified positions of employment in one of the following categories: Please check the box to indicate the category of your employment:

<input type="checkbox"/> Nursing Assistant	<input type="checkbox"/> Military Corpsman	<input type="checkbox"/> Medical Assistant	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Medication Tech	<input type="checkbox"/> Emergency Department Tech	<input type="checkbox"/> Respiratory Therapist	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Physical Therapist

**Note: If your experience is outside of these categories, continue to Page 2. You may fill out Page 2 to request an exception for your type of health care employment.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_



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- ***If you selected an Acceptable Healthcare Experience Category on Page 1, skip this page and go to Page 3.***
- If your healthcare experience is outside of the approved categories listed on Page 1 but you believe it is relevant to nursing, you may request consideration for an exception using this page.
- Each request will be evaluated on a case-by-case basis for equivalency by the Nursing Department Chair. The decision of the Chair is final.
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  - Paid or unpaid international or domestic hours of healthcare experience may be used.
- All pages of this document and any additional supporting documents must be uploaded in the documents section in the COCC Nursing application.
- Failure to upload this form or supporting documentation will affect consideration for experience points.
- **All required documentation must be uploaded to the application by May 1, 2026. Documentation submitted after that date will not be considered.**
  - By signing below, I certify that my information is complete and understand that providing false information on this form will result in nullification of application and/or dismissal from the program.
  - I understand that I am required to submit all pages of this form for my experience to be considered.

How do you believe your work experience is relative to nursing? Please explain:

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*\*\*\* If you filled out this page to request an exception, complete Page 3 next \*\*\*\*



<b>Part II: To Be Completed by The Supervisor or Human Resource Representative</b>		
<b>Supervisor or Human Resources Representative Contact Information:</b>		
Organization or Business Name:		
Organization or Business Address:		
Supervisor Name or HR Representative Name:		
Supervisor or HR Representative Title:		
Primary Contact Phone:		
Primary Contact Email:		
<b>Applicant's position title at your facility:</b>		
<b>Dates of employment/service:</b>	Begin Date:	End Date:
<b>Hours completed June 1, 2025 - May 1, 2026:</b>	Total Hours:	
Is this position a paid employee? (Please check one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are credentials required for this position? (Please check one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If YES, specify the credential type:</b>		
Provide a brief description below of the position/service performed <b>OR</b> attach a detailed job description:		

I verify the above-identified applicant's work experience and hours are complete and true, and they are in good standing and without performance concerns. COCC reserves the right to contact anyone listed on this form to verify this information. **Forms will not be accepted without a valid supervisor or HR representative signature.**

**Supervisor or HR Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_