Sacred Heart UNIVERSITY

PHYSICIAN ASSOCIATE STUDIES

VERIFICATION OF PATIENT CARE EXPERIENCE

This form must be completed in its entirety. Please submit one form per employer.

If your employer is no longer in business, or you are otherwise unable to verify hours via this form, you may submit a W2 statement or Payroll documentation that shows the number of hours worked. Self-employment may be verified by including a notarized statement, accompanied by paperwork verifying employment such as a tax statement.

To be completed by applicant:

Name: _____ Title/Position: _____
First M.I. Last

Employer: _____

Dates of Employment: **START** _____ (month/year) END _____ (month/year)

Date of CASPA Application submission:_____

How many hours of PAID employment were completed with this employer *between START date (above) and Date of CASPA Application submission (above)?*

_____ hours

To be completed by employer (manager or human resources):

I, _____(Please print name), **verify that the above named employee completed the claimed hours of paid employment at my business/organization.** His/her/their job responsibilities include(d) (please include *specific* tasks performed):

_____

_____

Signature:_____ Date: _____

Title: _____ Current Phone Number: _____

Name of Business/Organization: _____

Address: _____