COLLEGE OF SOUTHERN NEVADA
HEALTH CARE EXPERIENCE

For which **year** are you applying?

For which **track** are you applying? Circle one: Cardiac/Vascular
General/Vascular

Applicant name (please print)_____ NSHE ID #: _____
I give my permission to release the requested information to the CSN Diagnostic Medical Sonography Program.

Signature:_____Date:_____

Once this form has been completed and signed by employer, the applicant must submit with the completion packet to:

Limited-Entry Admissions, Room WCK216
College of Southern Nevada
6375 West Charleston Boulevard
Las Vegas, NV 89146

Employer Name:_____

Address:_____

Phone:_____

Name and title of person completing form (please print):_____

Provide a brief description of the agency (e.g. hospital, nursing home, home health, etc.):

Job title of applicant:

Provide a brief description of the responsibilities of the applicant:

Applicant employed from:_____to:_____

□ Full-time employment or □ Part-time employment

Would you rehire this person?

Please comment on the strengths and weaknesses of the applicant:

Employer Representative Signature:_____Date:_____