COLLEGE OF SOUTHERN NEVADA
SURGICAL TECHNOLOGY HEALTH CARE EXPERIENCE

For which **year** are you applying?

Applicant name (please print): _____NSHE ID#:_____

I give my permission to release the requested information to the CSN Surgical Technology 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 WCK 216
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):_____

Applicant Job Title:

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

Provide a brief description of the responsibilities of the applicant:

□Full-time employment or □ Part-time employment

Would you rehire this person?

Applicant employed from:_____to:_____

Please comment on the strengths and weaknesses of the applicant:

Signature:_____Date:_____