Health Care Experience Documentation Form
3 year Bachelor of Science Applicants

Applicants to the 3 year Bachelors of Science with a Major in Nursing program with any type of health care experience can fill out this form as part of the application process. Health care experience is not a requirement for being admitted into the nursing program and this form is not required in order for the application to be reviewed. However, additional consideration will be given for those with 400 or more hours of qualified health care work or volunteer experience.

ELIGIBILITY:

➢ Applicants must be applying to the 3 year Bachelor of Science with a Major in Nursing program to receive consideration for this type of experience. This experience is not considered for Accelerated Bachelors or RNBS applicants.

➢ Applicants can accrue health care experience hours from any point up to February 15th for consideration but no hours beyond this deadline will be considered in the total amount of hours accrued for this application cycle.

➢ Applicants can count health care experience for both work and volunteer activities as long as the activities are associated with a specific healthcare organization and were supervised by an official at that organization.

➢ Examples of experience that will be considered: CNA, LPN, MA, dental assistant, phlebotomist, PT aide, Doula, Licensed Acupuncturist, Licensed Massage Therapist. Experience that will not be considered: front desk office work, caring for a loved one, athletic trainer, pharmacy technician, vet tech, and lifeguard. These are not complete lists, if you have a question about your specific experience please email proginfo@ohsu.edu.

TO BE COMPLETED BY THE APPLICANT

Applicant First & Last Name: __________________________________________________________

(Please be sure to list any other names that your documentation may be listed under)

Email Address: ________________________________  Phone: ________________________________

Please indicate the number of volunteer/paid hours you have completed as of (date): ____________

☐ 400-1999 hours  ☐ 2000+ hours

Please list any certifications (if applicable): ________________________________________________

Agency Information: Please complete the following information for each organization that you have accrued health care experience. Any supervisor, manager, or HR representative can certify that the applicant has completed all of the hours identified on this form. OHSU reserves the right to contact anyone listed on this form to verify that this information is true and correct. Forms will not be accepted without a supervisor signature.

Agency Name: ________________________________  Title: ________________________________

Total # of hours accrued: ______________________  Dates Worked: _________________________
Brief description of position: ________________________________________________________________

________________________________________________________________________________________

Supervisor Name: _______________ Supervisor Title: _______________ Phone: _______________

Supervisor Signature: _______________________________________________ Date: _______________

Agency Name: _______________________________ Title: _______________________________

Total # of hours accrued: ___________________________ Dates Worked: ___________________________

Brief description of position: ________________________________________________________________

________________________________________________________________________________________

Supervisor Name: _______________ Supervisor Title: _______________ Phone: _______________

Supervisor Signature: _______________________________________________ Date: _______________

Agency Name: _______________________________ Title: _______________________________

Total # of hours accrued: ___________________________ Dates Worked: ___________________________

Brief description of position: ________________________________________________________________

________________________________________________________________________________________

Supervisor Name: _______________ Supervisor Title: _______________ Phone: _______________

Supervisor Signature: _______________________________________________ Date: _______________

Agency Name: _______________________________ Title: _______________________________

Total # of hours accrued: ___________________________ Dates Worked: ___________________________

Brief description of position: ________________________________________________________________

________________________________________________________________________________________

Applicant Verification:
I hereby certify that the above information is true and accurate. I understand that the information provided in this document will be used in the review of admission into the OHSU undergraduate nursing program and that providing false information on this form could be grounds for revoking an offer of admission and or dismissal from the program.

Applicant Signature: ______________________________________________

Upload this completed form to your Nursing CAS application.
Please contact the Admissions Office with any questions at proginfo@ohsu.edu or 503-494-7725.