

**Employer Verification**

This form must be completed by the applicant and contain the same information listed in the expanded portfolio. Once completed by the applicant, the employer will sign to attest to accuracy. Only one employer verification form is required as part of the application process. A current or former employer within the past 10 years must sign the verification form. For applicants who are self-employed, a colleague can attest to this form.

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| --- | --- |
| Applicant |  |
| First Name: |  |
| Middle Initial |  |
| Last Name: |  |
| Position/Title: |  |

|  |  |
| --- | --- |
| Place of Employment |  |
| Name: |  |
| Address: |  |
| City: |  |
| State: |  |
| Postal Code: |  |
| Country: |  |

|  |  |
| --- | --- |
| Employment setting (e.g. school, outpatient, home health, acute care, etc): |  |

|  |  |
| --- | --- |
| Employment Information |  |
| Dates of Employment |  |
| Start Date: |  |
| End Date: |  |

|  |  |
| --- | --- |
| Hours worked per week: |  |

|  |  |
| --- | --- |
| Number of patients managed per week: |  |

|  |  |
| --- | --- |
| Description of duties and responsibilities: |  |

|  |  |
| --- | --- |
| Is the applicant a clinical instructor? |  |
| If so, how many students per year? |  |

|  |  |
| --- | --- |
| Description of patient population across the life span (e.g. pediatrics, adults, geriatrics): |  |
|  | |

|  |  |
| --- | --- |
| Description of common diagnoses often treated in the clinical setting: |  |
|  | |

Employer Signature:

I attest the information above is correct.