

# VERIFICATION OF OBSERVATION/JOB-RELATED EXPERIENCE

Each applicant to the State Technical College of Missouri Practical Nursing program is required to set up and **complete** a total of 4 observation hours other than your current place of employment. **Two forms** must be submitted in order to receive credit for the observation experience. **This form (2 of 2)** must be submitted to comply with requirements for application to the program and should be completed by the nurse/supervisor overseeing of the observation experience.

**Completed by Applicant:**

Applicant's Name: \_\_\_\_\_

Name of Supervisor  
Overseeing Observation: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Facility Phone: \_\_\_\_\_

**Student Signature:** \_\_\_\_\_

**Completed by Supervisor:**

I am a **Licensed Practical Nurse (LPN) or Registered Nurse (RN)** and have served in the capacity as supervisor for the practical nursing applicant named above in the field of (place a check (✓) in the appropriate box below):

	PRACTICAL NURSING	Description:
<input type="checkbox"/>	Skilled Nursing (LTC)	
<input type="checkbox"/>	Clinic	
<input type="checkbox"/>	Hospital Acute Care Unit	
<input type="checkbox"/>	Other (Please Explain)	

If additional space is needed, please attach a separate piece of paper.

	Date of Observation	Total Hours	Nursing Care Observed

Comment on any work readiness skills, characteristics or qualifications observed that should be considered during the selection process for the PN program. <b>Please note that if this section is blank, the applicant will not earn credit for the experience.</b>

*I certify that the above information is accurate to my knowledge.*

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Please email completed form to:

**STATE TECHNICAL COLLEGE OF MISSOURI**  
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 Telephone: 573-897-5000