VERIFICATION OF WORK EXPERIENCE

Verification must be from an Office Manager, Licensed Physician, or Individual serving in Supervisory Role.

Applicant Name:

_____

Last Name First Name MI

I verify that the above-named applicant served as a(n) _____ from _____ (month and year) to _____ _____ (month and year).

_____

Name of Practice or Clinic Telephone Number

_____

Address City State Zip

_____

Printed Name of Verifying Individual

_____ _____

Signature of Verifying Individual Date

Please submit verification of medical experience to:

South Florida State College
Attention: Health Sciences
600 West College Drive
Avon Park, FL 33825
or email to healthsciences@southflorida.edu.

South Florida State College is an equal opportunity institution.