

SAN JACINTO COLLEGE
SURGICAL TECHNOLOGY PROGRAM
VERIFICATION OF HEALTHCARE-RELATED EXPERIENCE

The person listed below has applied for admission into our Surgical Technology Program.

Applicant name _____

Please verify that this applicant has been employed/volunteered with (name of business)

From (month/day/year)___/___/___ to (month/day/year)___/___/___

Averaging _____ hours per week as a (an)

(job title) _____

Please attach a general description of his/her duties while under your supervision/employment

SIGNATURE OF SUPERVISOR

DATE

SUPERVISOR'S NAME (PRINT)

SUPERVISOR'S TITLE

BUSINESS ADDRESS

BUSINESS PHONE

CITY

STATE ZIP CODE

Applicants please include this form in your program application. If you have questions email surgtechinfo@sjcd.edu

This form must be received by noon on the application deadline due date (June 1st for the fall admission, October 20th for the spring admission)