



DOCUMENTATION OF PAID HOURS REGISTERED NURSE

Use this form if 750 LPN work hours are complete.

APPLICANT: Complete the top section of this form then give to your employer(s) or former employer(s). This form may be duplicated.

*Please return completed form to:
Southeast Tech*

2320 N Career Ave Sioux Falls, SD 57107

Phone: 605-367-6040 **or** 800-247-0789

Fax: 605-367-8305

Email: Admissions@southeasttech.edu

Please Print

Applicant Name: _____
First Middle Last

I hereby request and authorize my employer/former employer to release the information requested on this form to Southeast Tech for verification of paid employment hours as an LPN.

Signature of Applicant Date

This section to be completed by employer (cannot be signed by the applicant):

The above named individual was employed as an LPN for _____ hours
from _____ to _____
Month/Date/Year Month/Date/Year

I, the undersigned, declare and affirm that according to our records and to the best of my knowledge and belief, the information provided above for the purpose of school entrance is true and correct.

Signature of Agency Representative/Title Date

Name of Employer: _____

Address of Employer: _____

Phone: _____ Email: _____



VERIFICATION OF EMPLOYMENT REGISTERED NURSE

Use this form if working, but LPN work hours are NOT complete.

APPLICANT: Complete the top section of this form then give to your employer(s) or former employer(s). This form may be duplicated.

Please return completed form to:
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2320 N Career Ave Sioux Falls, SD 57107
Phone: 605-367-6040 **or** 800-247-0789
Fax: 605-367-8305
Email: Admissions@southeasttech.edu

Please Print

Applicant Name: _____
First Middle Last

I hereby request and authorize my employer/former employer to release the information requested on this form to Southeast Tech for verification of paid employment hours as an LPN.

I understand that when I have completed the required 750 hours of employment, I must submit the required documentation form.

Signature of Applicant _____
Date

This section to be completed by employer (cannot be signed by the applicant):

The above named individual was employed as an LPN for _____ hours/week

Start Date _____ Hours completed at time of application _____
Month/Date/Year

I, the undersigned, declare and affirm that according to our records and to the best of my knowledge and belief, the information provided above for the purpose of school entrance is true and correct.

Signature of Agency Representative/Title _____
Date

Name of Employer: _____

Address of Employer: _____

Phone: _____ Email: _____