RUTGERS

Nursing Experience Form

Human Resources

Last Name:	First Name:	ID# or SSN:
Job Title:	Facility:	
Work Phone:	Home/Cell Phone:	

Date received RN License:

Degree/Certification Information:

List Degree(s)	Date Completed	List Nursing Certifications	Expiration Date
(1)		(1)	
(2)		(2)	
(3)		(3)	
(4)		(4)	

Documented Experience – Starting with the most recent experience:
Specify if Doctor's Office **(Attach additional sheets if needed)**

(1) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:

Documented Experience:
Specify if Doctor's Office **(Attach additional sheets if needed)**

(2) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:

Documented Experience:
Specify if Doctor's Office **(Attach additional sheets if needed)**

(3) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:

Documented Experience:
Specify if Doctor's Office **(Attach additional sheets if needed)**

(4) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:

Documented Experience:
Specify if Doctor's Office **(Attach additional sheets if needed)**

(5) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:
Documented Experience: ***Specify if Doctor's Office***		**(Attach additional sheets if needed)**
(6) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:
Documented Experience: ***Specify if Doctor's Office***		**(Attach additional sheets if needed)**
(7) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:
Documented Experience: ***Specify if Doctor's Office***		**(Attach additional sheets if needed)**
(8) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:
Documented Experience: ***Specify if Doctor's Office***		**(Attach additional sheets if needed)**
(9) Employer Name:		Type of Nurse: ☐RN ☐LPN ☐APN
Begin Date:	End Date:	Facility Type: ☐Acute Care ☐Long Term ☐Correctional ☐Agency ☐Other:_____
Status: ☐FT ☐Part-Time ☐Per Diem		Country:
Break In Service:		
Is the break in service equal to or greater than 18 months from the most recent nursing experience (last employer)? ☐Yes ☐No		
If yes, please state Begin Date:_____ End Date:_____		
Additional Comments:		

Employee Signature:_____ **Date:**_____