FAIRFIELD UNIVERSITY NURSE ANESTHESIA PROGRAM
CRITICAL CARE NURSE EMPLOYMENT VERIFICATION FORM

INSTRUCTIONS

1. The applicant must provide this form to their nurse manager or director for completion.
2. The form must be submitted directly to the requesting party or department.
3. This form must be completed in its entirety and signed by the Nurse Manager or Director.

APPLICANT INFORMATION

Name: ____

Job Title: ________________________________ Department: __________________

Full-Time/Part-Time Status: ____________________ Date of Hire: __________________

TO BE COMPLETED BY NURSE MANAGER OR DIRECTOR

This section must be completed by the nurse's direct supervisor or department head only (Nurse Manager or Director). No other employee may complete this form.

Name of Supervisor: ____

Job Title: ________________________________ Department: __________________

Phone Number: __________________ Email Address: __________________________

EMPLOYMENT VERIFICATION

1. Is the above-named employee currently employed in your department since the date listed above? ☐ Yes ☐ No
2. Is the employee currently working full-time in the Intensive Care Unit (ICU)? ☐ Yes ☐ No
   If No, please specify the current role and location:
   ____
3. Has the employee been consistently employed in the ICU since their date of hire?
   ☐ Yes ☐ No
   If No, please explain:
   ____
4. Additional comments or notes (optional):
   ____

CERTIFICATION

By signing below, I certify that the information provided is accurate and reflects the nurse's current employment status in the ICU as of the date below.

Supervisor's Signature: ______________________________ Date: ________________