Experience Form

Health & 2nd Tier Admission Programs

Washtenaw Community College

For programs that offer this option, students may receive additional points on their Health & 2nd Tier Program Application for **direct patient care employment** experience in a **hospital or health care facility or agency** provided the experience was completed **within 8 years** of the application deadline. This form must be attached to any experience submitted and a **separate form is required for each employer**.

Direct patient care involves any hands-on interactions between healthcare professional and patients that is intended to diagnose, treat, manage, adjust the treatment plan for a patient's medical condition. This includes, but is not limited to performing physical examinations, conducting procedures, taking vital signs, providing personal hygiene assistance, transporting patients, educating patients about their medical condition and how to manage it, and making necessary adjustments to the treatment plan based on the patient's response. Direct patient care requires direct interaction with patients to assess their needs and provide necessary care and treatment.

Submit to: Health & 2nd Tier Admissions Office at healthadmissions@wccnet.edu or Student Welcome Center (2nd Floor, Student Center).

TO BE COMPLETED BY STUDENT:

Name: _____ **Student ID:** _____

Please select the program and indicate the year this form is being submitted for:

☐ Physical Therapist Assistant (APPTA) – **Program Start Year:** _____

☐ Radiography (APRAD) – **Program Start Year:** _____

Please select the option that applies to your employment status:

☐ I am/was employed **full-time** (30 hours or more per week).

☐ I am/was employed **part-time** (15 hours or more per week but less than 30 hours).

TO BE COMPLETED BY EMPLOYER:

Employer Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Dates of Employment (mm/dd/yyyy): From: _____ **To:** _____

Are you still employed? ☐ **Yes** ☐ **No**

The above student **is/was employed for** _____ **hours per week** during the dates listed above.

List key direct patient care job duties and services performed below or attach job description:

Supervisor's Name: _____ *-Tape business card here-*

Job Title: _____

Phone Number: _____ **Date:** _____

***Signature:** _____

***Electronic signatures are valid only if sent from the employer's official email.** Paper forms must have a handwritten signature and include a business card or letterhead for verification.