Southeastern
COMMUNITY COLLEGE

LPN-ADN Transition Program

Verification of Practice

By my signature, I affirm that _____

(Print full name and LPN)

☐ is working or ☐ has worked in the role of Licensed Practical Nuse.

(Check one.)

Employment Dates:

Start: _____ End: _____ ☐ Still Employed

Facility (check one):

☐ Acute care hospital or ☐ Skilled Nursing Facility

or ☐ Other _____

Name and type of facility _____

Total hours worked for the year _____

_____ _____

Employer Signature from Nursing Manager or Human Resources Department Date

_____

Printed Name and Title

_____

Printed Name of Facility/Agency

_____

Contact Phone Number

Applicants may duplicate this **BLANK form if multiple copies are needed.**