STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov

RECORD OF EXPERIENCE

PRINT OR TYPE (DO NOT USE PENCIL).

1. NAME (LAST)	(FIRST)	(MIDDLE)
2. ADDRESS	(STREET OR BOX NUMBER)	(APT. NO)
3. CITY	STATE	ZIP
4. BIRTHDATE (Month/Day/Year)	5. SOCIAL SECURITY NUMBER*	6. TELEPHONE NUMBERS BUSINESS ( )_____ HOME ( )_____ AREA CODE

EXPERIENCE: List your experience record for the past ten (10) for which you will be submitting verification of employment. It is your responsibility to contact each employer and provide them with a copy of the Employment Verification form for completion.

7A. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	*THIS SPACE FOR OFFICE USE ONLY*
7B. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7C. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	

PLEASE READ CAREFULLY BEFORE SIGNING. *– I hereby certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. False statements included in this application can result in licensure denial.*

SIGNATURE:_____ DATE:_____

7D. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	*THIS SPACE FOR OFFICE USE ONLY*
7E. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7F. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7G. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	
7H. Name of Hospital, Registry or Health Agency: _____ Name of Supervisor: _____ Your name while employed at this facility:	Type of Duty: ☐General ☐Private Type of Patient Care for: ☐Mental Disorders ☐Developmental Disabilities ☐Medical Surgical ☐Other:_____	Employment Period From: _____ Month Day Year To: _____ Month Day Year	

* **SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT –**

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c)(2)(C))] authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.