



EMPLOYMENT VERIFICATION FORM

INSTRUCTIONS TO APPLICANT:

- Complete Part I on the second page of this form and provide a copy of both pages to each employer for the past ten (10) years. (You may reproduce as many copies of this form as needed.)
- This form must be completed in full by the Supervisor and **returned directly to you in the employer's sealed business envelope. The UNOPENED sealed envelopes containing the Employment Verification Forms must be submitted to the Board with your Application for Psychiatric Technician Licensure.**
- If you already have an application on the file with the Board and are submitting additional experience, the employment verification form may be submitted to the Board by the applicant or the employer, but must be received in the employer's sealed business envelope.

Please be advised that employment verification forms that appear to have been opened or altered will not be accepted. The Board conducts random audits to verify the accuracy of the information submitted. Discrepancies or false statements included in the application can result in licensure denial.

INSTRUCTIONS TO EMPLOYER:

The applicant on page two of this form is applying for licensure as a psychiatric technician under Section 4511 of the Business and Professions Code. In order for the applicant to receive credit for paid work experience, State law requires the Board to obtain verification of employment from the Supervisor.

- Please complete Parts II and III on page two of this form and **return it to the applicant in a sealed business envelope.** Indicate on the outside of the envelope **"Employment Verification Enclosed – Do Not Open"**. It is the applicant's responsibility to collect the Employment Verification Form(s) and submit them with the application for licensure.
- **Part II:** Indicate the name and type of facility where the experience was obtained.
- **Part III:** Provide the specific dates that the applicant worked under your supervision, in the area being verified. Additionally, indicate if the applicant was employed full time (40 hrs./wk.) or part time and **include the number of hours worked in each area.** The Board **MUST** receive a breakdown of the number of hours spent in each area, in order to evaluate the experience.

Thank you for your assistance. Please feel free to contact the Board at (916) 263-7830 if you have any questions.

BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS

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Part I is to be completed by the applicant and submitted to employers for verification of work experience. The remainder of this form must be completed by the Supervisor and returned to the applicant by the employer in a sealed business envelope. FORMS CONTAINING STRIKEOUTS OR CORRECTIONS WILL NOT BE ACCEPTED. (See Page 1 for detailed instructions on how to complete this form.)

Part I: To be completed by the Applicant (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. NAME WHILE EMPLOYED AT THIS FACILITY:	5. SOCIAL SECURITY NUMBER* <small>*NOT required, but may assist employer in locating records</small>	6. DAYTIME TELEPHONE NUMBER () _____ Area Code

Part II: To be completed by the Employer - Indicate the name and type of facility where the experience was obtained:

Name of facility where experience was obtained:
Medical-Surgical Nursing Science Clinical Experience - Type of Facility: <input type="checkbox"/> Acute or sub-acute(hospital) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Convalescent <input type="checkbox"/> Home Health <input type="checkbox"/> Outpatient Clinic/Emergency Care <input type="checkbox"/> Skilled Nursing/Long Term Care <input type="checkbox"/> Other:
Mental Disorders Clinical Experience - Type of Facility: <input type="checkbox"/> Acute Psychiatric Hospital <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Long Term Psychiatric Facility <input type="checkbox"/> Mental Health Clinic <input type="checkbox"/> Substance Abuse Unit <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Other:
Developmental Disabilities Clinical Experience - Type of Facility: <input type="checkbox"/> Day Treatment Center <input type="checkbox"/> Private Developmental Center <input type="checkbox"/> Rehabilitation Center <input type="checkbox"/> Residential Care Home <input type="checkbox"/> State Developmental Center <input type="checkbox"/> Other:

Part III: To be completed by the Employer - Include dates and the area of nursing being verified. Indicate if employment was full-time (40 hrs/wk) or part-time and include the total number of hours worked in each area:

Areas of Paid Work Experience	Employment Period: (Month/Date/Year)	Hours Worked Per Week	Total Hours In Each Area	For Office Use Only
Mental Disorders	From: / / To: / /			
Developmental Disabilities	From: / / To: / /			
Medical-Surgical Nursing	From: / / To: / /			
Other:	From: / / To: / /			

TO BE SIGNED BY THE SUPERVISOR:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

Signature: _____
 License # _____ Exp. Date: _____
 Address: _____
 City/State: _____ Zip Code: _____

Print Name _____
 Telephone Number: (____) _____
 Today's Date: _____