National Healthcare Workers Association (NHCWA)
Related Work Experience Verification Form

Directions

Thank you for taking the time to assist the applicant named below verify and document his or her related work experience in the field of Medical.

Please carefully read the Related Work Experience Form below. If you have any question as to whether or not specific duties or tasks are eligible to meet Related Work Experience Requirements, please contact our offices directly

To document the applicant's related work experience you must complete this form in its entirety and attach supporting documentation describing the duties and tasks performed by the applicant, such as a position description. In the absence of an official position description, a narrative and listing of duties written on agency letterhead may be provided.

Please do not ask the applicant to complete any part of the form, **except Part 1**. It is our policy that the applicant's employer's personnel officer, volunteer supervisor, or designee completes this form only.

Upon completion, please submit the form and supporting documentation directly to NHCWA via fax or email. The applicant can also submit this form in its entirety.

NHCWA
378 Boston Post RD Suite1000
Orange, CT 06477
Phone: 855-378-3132 Fax: 877-560-9486
Email: NHCWACERTIFICATIONINFO@gmail.com

Description of a Qualified Healthcare Professional

The participants must be qualified health care professionals based on criteria set forth by the certification agency.

Pre-requisites for Program Participation:

Our certification and continuing education programs are only designed for those persons who possess competency in the healthcare field, and have a prior background in healthcare by way of experience, schooling, and/or job training, such as:

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (safe, consistent, and successful) in performing each of the critical skill areas as identified below. (Note: Actual patient care verification in an ambulatory care, medical office, or clinic environment is required.

National Healthcare Workers Association

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Part 1: To be completed by the applicant prior to providing to the employer for completion.

Applicant Information. Please list your employment history for which you are requesting for certification and verification by your employer. Report employment dates in the following format: May 2000 – Aug 2004. Use a separate form for each position and/or employer.

Applicant Name: **Phone #**

Applicant Address: ______________________ **Email:** ______________________

Employer: ______________________ **Type of Position (select all that apply):** ▯ Full-time ▯ Part-time ▯ Paid ▯ Volunteer

Position Title: ______________________

Employment Dates: ______________________

Immediate Supervisor: ______________________

Part 2: To be completed by the personnel officer, volunteer supervisor or designee only.

Section A: Verifier's Information

Last Name	**First Name**
Title	**Employer**
Employer Webpage Address	**Business Phone**
Work Address Line 1	
Work Address Line 2	
City	**State**
Zip code	**County**

Section B: Experience Attestation

I have read and understand the on-the-job experience requirements for National Healthcare Workers Association (NHCWA) certification program. Employment records maintained by the agency can verify the following information.

Applicant's Position Description Attached? ❒ Yes ❒ No*

*If no, please attach a written description of the applicant's duties on agency letterhead.

Applicant's Dates of Employment: ______________________

Type of Position (select all that apply): ▯ Full-time ▯ Part-time ▯ Paid ▯ Volunteer

Average number of hours per week providing related services: ______________________

By my signature, I attest that the above material is true to the best of my knowledge.

____

Signature **Date**

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Related job duties: Please briefly describe employee's major functions and/or attach a copy of their job description to this form. Please include duties not related to healthcare as well. Note: if paid hours per week vary over the time of employment at the same job, the certification board will request a letter of explanation.

Vital Signs/Measurements	**Initials**
ECG Performances	**Initials**
Sterile Technique	**Initials**
Venipuncture	**Initials**
Nursing Assistant skills	**Initials**
Capillary Puncture	**Initials**
ECG Performance	**Initials**
Identification of Basic Rhythm, Artifacts, Interference	**Initials**
Equipment Care, Use, maintenance	**Initials**
Holter Monitor	**Initials**
Claims Processing	**Initials**
CPT Coding	**Initials**
ICD-9-CM & HCPS Level II Coding	**Initials**
Medical Office Computers	**Initials**
Vital Signs, Exam Preparation, Office Emergencies	**Initials**
General Principles	**Initials**
Basic financial medical record management	**Initials**
Equipment and supply	**Initials**
Appointments and scheduling	**Initials**

Signature Title Date