

Community College – Nursing Program  
Clinical Experience Recommendation Form

To be completed by the applicant.

|                            |                    |                                  |
|----------------------------|--------------------|----------------------------------|
| <i>Last Name</i>           | <i>First Name</i>  | <i>Name of Facility/Employer</i> |
| <i>Type of Unit/Floor</i>  | <i>Phone/email</i> |                                  |
| <i>Dates of Employment</i> |                    |                                  |

**The following information is to be filled out by the applicant’s direct clinical manager.**

Please indicate if the applicant named above has demonstrated experience with:

|  | Demonstrated Experience | NO demonstrated Experience | Comment |
|--|-------------------------|----------------------------|---------|
| PO Medication Administration                       |                         |                            |         |
| IV Medication Administration                       |                         |                            |         |
| Documentation of Client Health/Physical Assessment |                         |                            |         |
| Skills requiring sterile technique                 |                         |                            |         |

Please indicate if you recommend this employee for admission to the RN Nursing Program.

\_\_\_\_\_ Recommend \_\_\_\_\_ Do not Recommend

Comments:

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Signature \_\_\_\_\_  
 Title: \_\_\_\_\_ Date \_\_\_\_\_

Please return completed form to the Nursing Program Director, Carroll Community College.