MICHIGAN STATE UNIVERSITY | College of Nursing

CRITICAL CARE EXPERIENCE

INSTRUCTIONS

Applicants, please fill out the top portion of this form then forward to your supervisor, manager, Human Resources Office for verification of the Employer Section. If you have acquired ICU experience in more than one hospital system, please provide a form for each place you have worked in an ICU. Employers, please verify the full-time equivalent hours of ICU experience completed by the applicant identified below. Orientation or Internship hours are not eligible for consideration in total critical care experience hours. Once complete, return the form to the applicant. **Applicants must upload the Critical Care Forms to their application no later than 11:59pm on the day the application closes.** *Please note that email attachments ***must be in PDF format***.

Name: (Last)_____ (First)_____(M.I.)_____

(Home Phone)_____(Cell Phone)_____(Email)_____

CRITICAL CARE EXPERIENCE	Number Managed Last Month	Number Managed independently	Number Managed w/assistance	No experience
Arterial Line				
Central Venous Pressure				
Swan Ganz Catheter				
Intra-aortic balloon pump				
Ventilators				
CRT				
ECMO				
Other (please specify) _____				

Clinical Background. Indicate the applicant's primary area of clinical practice. (Please indicate the number of years of *full time* experience you have in the following areas).	**Critical Care**	**Years of Experience**
Other (please specify)_____	MICU	
	SICU	
	CCU	
	TRAUMA ICU	
	NEURO ICU	
	NICU	
	PICU	

Applicant Authorization to Release Information:

I, _____, authorize my current and/or past employer to release information regarding the number of full time equivalent years I worked in a critical care under their employ. I understand this information will only be used to determine my eligibility for the Michigan State University College of Nursing DNP Nurse Anesthesia Program.

_____ _____

Signature Date

EMPLOYER SECTION

Employer Verification:

The above mentioned individual is applying to the Michigan State University College of Nursing Nurse Anesthesia Program. Please verify the number of FTE years this individual has been employed in a critical care unit with your organization.

Name of Applicant_____

Total number of **Full-Time Equivalent Years** working in a Critical Care Unit:_____

***Please note that ORIENTATION HOURS are INELIGIBLE for Inclusion in total hours.**

Employer Representative Information:

Signature_____ Phone_____

Printed Name and Title_____ Email_____