



**Northern Virginia
Community College**

Medical Education Campus

**NORTHERN VIRGINIA COMMUNITY COLLEGE
SURGICAL TECHNOLOGY PROGRAM
DOCUMENTATION OF CLINICAL WORK EXPERIENCE FORM**

Applicants must use a **separate** form for documenting all work experience from different medical facilities.

Applicant's Name: _____

Physician's/Manager's Name: _____

Office Address: _____

Street Address

City

State

Zip Code

Office Telephone: _____

Telephone Number

Office E-mail Address: _____

Applicant's Position Title: _____

Dates of Service: _____ to _____

Month/Year

Month/Year

Please indicate if the Applicant was:

Full-Time $\geq$ 32 hours/week: _____

or Part-Time: _____

If Part-Time: Hours per Week _____

I certify that the above information is correct and accurate for this applicant who is applying to Northern Virginia Community College's Surgical Technology Program.

Physician's/Manager's Signature

Date

NOTE: This is the official form that must be used for the documentation of all clinical work experience prior to September 2026. There are to be **NO** substitutions such as letters when accounting for work experience in a clinical setting. This form will be considered valid documentation of work experience for 2 application cycles (2026, 2027).