
To the Applicant

Applicants must have a **minimum of two years** of current clinical experience, excluding orientation) as an RN in a critical care setting, which must be completed within the last three (3) years by the time of application.

This experience **must be completed at one of the following:**

- a. Surgical Intensive Care Unit (SICU)
- b. Medical Intensive Care Unit (MICU)
- c. Cardio-Thoracic Intensive Care Unit (CTICU)

Experience in the following settings (d, e, f, or g) will be accepted, **ONLY** if combined with one of the experiences listed above (a, b, or c) for a minimum of one year.

- d. Neurosurgical Intensive Care Unit (NeuroICU)
- e. Neonatal Intensive Care Unit (NICU)
- f. Pediatric Intensive Care Unit (PICU)
- g. Coronary Care Unit (CCU)
- h. **Applicant Name:** _____

Print legibly

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1. **Submit a Certificate of Completion of a Critical Care course** (staple to this form)
 2. **Submit a letter from an immediate supervisor who can comment on your clinical skills and expertise in this area** (on letter head, with telephone number at which the immediate supervisor may be contacted).
 3. **Complete Form 1 and forward it along with Form 2 to Human Resources for each institution you have worked.**
 4. **The signed copy of Form 1 and Form 2 are to be returned to SUNY Downstate by Human Resources (HR) in a sealed envelope with HR's signature across the seal.**

I give my permission for the requested information to be completed and released.

Applicant's Signature

Date

5. **To be Completed by the Applicant** (you may attach a separate sheet of paper and staple to this form):

- a. **Identify the Setting in which the critical care experience was obtained**
 - b. **Dates of Employment in the Critical Care setting**
 - c. **Nature of the Experience and Clinical Skills**
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**SUNY
DOWNSTATE**
Medical Center

2016 NURSE ANESTHESIA PROGRAM
**VERIFICATION OF CRITICAL
CARE EXPERIENCE**
FORM 2

To Human Resources:

Please verify Intensive Care Unit (ICU) experience for:

Applicant's Name: _____

Applicant's Job Title: _____

Department: _____

Unit: _____

Dates of employment: _____

Dates of employment in the **critical care unit**: _____

Standard Hours: _____

Signed by Human Resources:

Print Name and Title: _____

Name of Hospital: _____

Phone Number: _____

This form is not to be returned to the applicant but to be mailed with signature across the seal to:

SUNY Downstate Medical Center
Office of Student Admissions
450 Clarkson Avenue, MSC 60
Brooklyn NY, 11203-2098