CLINICAL HOURS VERIFICATION FORM

Please use this form to document your clinical hours.

Instructions

- Complete one form for each clinical supervisor with whom you worked.
- Clinical supervisor must sign the bottom portion of this form for "Supervisor".
- Exam applicants must sign the attestation statement.
- Return completed form to Meazure Learning at the address listed below.
- All materials must be returned to Meazure Learning within 90 days of the date of your online exam application submission.

CANDIDATE SECTION

CLINICAL EXPERIENCE (REPORTED BY CANDIDATE)

Candidate Name:		Candidate Email:	
Facility where clinical hours completed:			
Start Date:		End Date (Or today's date):	
Supervisor Name:		Supervisor Telephone:	
Supervisor's Credentials / Title:			
Address:			
City:	State:	Zip Code:	Country:
Clinical Hour Total and Notes:			

Attestation:
I authorize investigation of clinical experience listed above and as verified below by supervisor and to provide Meazure Learning, on behalf of WOCNCB, any and all information concerning my current and/or previous experience.

_____ _____

Signature of Candidate Date

END OF CANDIDATE SECTION

CLINICAL SUPERVISOR SECTION

The above individual has applied to become a wound care WTA-C professional. WOCNCB is verifying the clinical hours were in the field of patient wound care. Please verify below:

_____ YES, the above clinical hours is accurate.

_____ _____

Signature/Title Date

Candidates: Return completed form to:
Online: https://assessments.meazurelearning.com/connect/WOCNCB-WTA
Mail: Registration Manager, WTA-C Program
c/o Meazure Learning, PO Box 570, Morrisville, NC 27560-0570
Telephone: 919.572.6880