Cypress-Fairbanks Independent School District

Melinda Hood
Director
Health Services
281-897-4015
Fax 281-517-2107

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281-897-4099
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FOR NURSING SERVICE OUTSIDE OF PUBLIC SCHOOLS

To the Registered Nurse:

The attached form letter is to be used to request your prior nursing record for experience outside of the public school setting.

Please complete the form showing your full name, social security number and fill in columns one through four. See the sample form for assistance in listing your service experience. Remember, no more than one year of experience can be shown on one line, or earned during one calendar year.

Mail this form to your previous employer for completion of columns six through eight, and the authorized personnel representative's signature and title in column nine.

Please have this form returned to you as you will need to sign it before we can review it for acceptance of your record. Return the form to my office after it is complete.

Thank you,

Melinda Hood,
Director of Health Services

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_____
Date

_____
Previous Employer

_____
Address

_____
City, State, Zip

Re:_____
Nurse's Name

_____
Social Security Number

To Whom It May Concern:

I have been employed by the Cypress-Fairbanks ISD and need a record of my experience so I may receive credit for salary purposes.

I have listed my experience on the attached form. Please have the authorized personnel person complete and verify with their signature each year of service, and return the form to me.

Your cooperation will be greatly appreciated.

_____
Signature

_____
Address (Street and Number)

_____
City State Zip

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GUIDELINES FOR AWARDING CREDIT FOR PRIOR NURSING EXPERIENCE OUTSIDE OF PUBLIC SCHOOLS

The following are the criteria which must be met for Cypress-Fairbanks ISD to accept or credit prior Nursing experience toward total years of experience.

- Full-time, full-year Nursing experience
- Experience in a clinic, hospital or private practice
- Experience must be verifiable by service or employment record
- Credit will not be given for substitute services, clinical practicum, or service as an aide, student assistant or teaching fellow
- Credit for experience may not be grated from more than one entity in any given academic year

Cypress-Fairbanks Independent School District

Kathleen Corbett
Director Human Resources
(281) 897-4099

VERIFICATION OF ACCREDITATION STATUS

NAME:_____

SSN:_____

The individual named above is a current employee of the Cypress-Fairbanks Independent School District and has indicated previous employment with your institution during the _____ year(s). The information requested below is needed to determine whether the experience being claimed may be counted under our current nursing salary law. To assist us in our evaluation, we respectfully request that the following questions be answered:

1. Was the facility or institution during the year(s) indicated above a **recognized accredited university-operated hospital** or approved by a United Sates Regional Accrediting Agency? _____

   If yes, the name of the University or accrediting agency was:

   _____

3. Is this a public or private school? (if applicable) Public_____ Private_____

We appreciate your cooperation in completing this form at your earliest convenience.

_____
Signature of person completing this form

_____
Printed name and title

_____
Facility or Institution Name
Phone Number

10300 Jones Road
Houston, Texas 77065

P. O. Box 692003
Houston, Texas 77269-2003

Instructions for Completing Form
(All columns must be completed unless otherwise indicated)

1. Year – Corresponds to the school term or scholastic school year (September 1 – August 31) that employment is claimed. **No more than one year of experience can be shown on one line.**

2. State or Country – Enter state or territory of USA. Enter name of Foreign Nation if applicable.

3. County or Equivalent – Enter county or parish in USA. Enter APO of Department of Defense (DOD) Schools and names of sub-territories of Foreign Nations.

4. Hospital or Institution – Enter name of the hospital, public school district, and/or other institutions. Give sufficient information in this column to identify the hospital or institution for accreditation purposes.

5. Enter Position – In order to receive credit the employee would have to have been a registered nurse at the time of employment.

6. % of Days Employed – Enter percentage of the day employee is employed. Full day is reported as 100%, one-half day is reported as 50%.

7. No. of Days – Enter the number of days employed during the year or school term for public schools and private schools. An employee must have been a registered nurse and served in a position for at least 90 full-time days for experience to be acceptable for salary credit. **We will not be able to accept the service record without this column completed**.

8. Dates of Service – Enter beginning and ending dates of employment in the year or school term.

9. Only Authorized Signatures Acceptable – Each line on the record must be verified by the signature and title (in ink) of an authorized official of the school system involved. Such official, must have been authorized to sign personnel records of the institution by the governing board of that institution.

*This is a legal document: erasures, ditto marks, liquid paper corrections and stamped signatures are not acceptable.

See Sample on Reverse Side

Name SMITH MARTHA A

(Last) (First) (Middle Initial)

Please print or type

Social Security No. 451-97-1174

Written Signature of Teacher

NURSING SERVICE RECORD

FOR VERIFICATION OF SERVICE

USE A SEPARATE LINE FOR EACH YEAR. This is a legal document:erasures, ditto marks, liquid paper corrections and stamped signatures are not acceptable.

(1) Year	(2) State	(3) County	(4) Hospital or Institution	(5) Position	(6) % Day Employed 50% = half day 100% = full day	(7) No. Days Worked	(8) Beginning Work Date Mo. Day Yr.	(8) Ending Work Date Mo. Day Yr.	(9) Signature of Superintendent, trustee, or personnel administrator (each line)
1966-67	Ohio	Tarrant	Medical Center of Ohio	RN	100%	183	8/12/1966	5/29/1967	*Robert Smith*
1967-68	Ohio	Tarrant	Medical Center of Ohio	RN	100%	91	1/6/19[illegible]	5/29/1968	Supt. *Robert Smith*
1968-69	Ohio	Tarrant	Medical Center of Ohio	RN	100%	190	8/1[illegible]1968	5/29/1969	Supt. *Robert Smith*
									Supt.

Please State Title

Name _____

(Last) (First) (Middle I)

Please print or type

Social Security No. _____

_____

Signature of Nurse

NURSING SERVICE RECORD

FOR VERIFICATION OF SERVICE

USE A SEPARATE LINE FOR EACH YEAR OF SERVICE. This is a legal document:erasures, ditto marks, liquid paper corrections and stamped signatures are not acceptable.

(1) Year	(2) State	(3) County	(4) Hospital or Institution	(5) Position	(6) % Day Employed 50% = half day 100% = full day	(7) No. Days Worked	(8) Beginning Work Date Mo. Day Yr.	(8) Ending Work Date Mo. Day Yr.	(9) Signature of Superintendent, trustee, or personnel administrator (each line)

Please State Title

*Please list any breaks in service