HEALTH CARE EXPERIENCES

HEALTH CARE AGENCY NAME & ADDRESS	DATES FROM: mo/day/yr	DATES TO: mo/day/yr	Total Number of Hours worked	SUPERVISOR & PHONE NUMBER
Position/Title:				
Briefly describe your responsibilities (use separate sheet of paper if necessary)				☐ Paid ☐ Volunteer ☐ Full Time ☐ Part Time

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Briefly describe your responsibilities (use separate sheet of paper if necessary)				☐ Paid ☐ Volunteer ☐ Full Time ☐ Part Time