

**Commission of the Council on Occupational Education
EMPLOYER PROGRAM VERIFICATION FORM
for Postsecondary Programs**

INSTRUCTIONS:

- Complete three of these forms for **each service area** served by the program.*
- This form **must** be signed by an employee who is in position to make hiring decisions on behalf of the employer.

Name of Institution FLORIDA VOCATIONAL INSTITUTE		
Address 7757 West Flagler st suite 220		City/State/Zip Miami FL 33144
Name of Patient Care Technician		
Mode(s) of Delivery of Program (check ALL that apply):		
<input checked="checked" type="checkbox"/> 100% Traditional	<input type="checkbox"/> Hybrid	<input type="checkbox"/> Distance Education

The length of this program is (indicate the number of hours in all boxes that apply):

<input type="text" value="600"/> Clock Hours	<input type="text"/> Semester Credit Hours	<input type="text"/> Quarter Credit Hours
--	--	---

The amount of tuition and fees charged for the total program is: \$

EMPLOYERS' VERIFICATION STATEMENT

I have reviewed the (name of program): Richard Ruiz RN BSN
program and recommended requirements for admissions, program content, program length, program objectives, competency tests, instructional materials, equipment, method of evaluation, the skills and/or proficiency required for completion, and appropriateness of the instructional delivery method(s) for the program.

EMPLOYER

Name: <u>Richard Ruiz RN</u>	Title: <u>RN BSN</u>
Company Name: <u>Kindred Hospital</u>	Phone Number/Extension: <u>305-448-1585</u>
Address: <u>5190 SW 8 Street</u>	City/State/Zip: <u>Coral Gables FL 33134</u>
Verifiable range of remuneration (based on year-round, full-time employment) that can reasonably be expected by those who enter this field upon completion of the program is from \$ <u>25,000</u> annually to \$ <u>25,900</u> annually.	
Signature: <u>[Signature]</u>	Date: <u>01/25/16</u>

(March 2015)

Commission of the Council on Occupational Education
EMPLOYER PROGRAM VERIFICATION FORM
for Postsecondary Programs

INSTRUCTIONS:

- Complete this form for **each service area** served by the program.*
- This form **must** be signed by an employee who is in position to make hiring decisions on behalf of the employer.

Name of Institution Florida Vocational Institute		
Address 7757 W Flagler Street Suite 220		City/State/Zip Miami, Florida 33144
Name of Program Patient Care Technician		
Mode(s) of Delivery of Program (check ALL that apply):		
<input checked="checked" type="checkbox"/> 100% Traditional	<input type="checkbox"/> Hybrid	<input type="checkbox"/> Distance Education

The length of this program is (indicate the number of hours in all boxes that apply):

<input type="text" value="600"/> Clock Hours	<input type="text"/> Semester Credit Hours	<input type="text"/> Quarter Credit Hours
--	--	---

The amount of tuition and fees charged for the total program is: \$

9,849.00

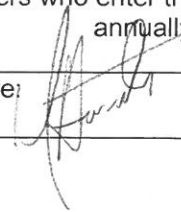
EMPLOYERS' VERIFICATION STATEMENT:

I have reviewed the (name of program): Patient Care Technician and Nursing Assistant/Home Health Aide

program and recommended requirements for admissions, program content, program length, program objectives, competency tests, instructional materials, equipment, method of evaluation, the skills and/or proficiency required for completion, and appropriateness of the instructional delivery method(s) for the program which include (check **ALL** that apply):

<input checked="checked" type="checkbox"/> 100% Traditional	<input type="checkbox"/> Hybrid	<input type="checkbox"/> Distance Education
---	---------------------------------	---

EMPLOYER

Name: <u>Michel Huarte</u>	Title: <u>RN, SBN</u>
Company Name: <u>Southern Winds Hospital</u>	Phone Number: <u>305-558-9700</u>
Address: <u>4225 W 20 Ave</u>	City/State/Zip: <u>Aviation FL 33002</u>
Verifiable range of remuneration (based on year-round, full-time employment) that can reasonably be expected by completers who enter this field upon completion of the program is from \$ _____ annually to \$ _____ annually.	
Signature: 	Date: <u>1/15/14</u>

Commission of the Council on Occupational Education
EMPLOYER PROGRAM VERIFICATION FORM
for Postsecondary Programs

INSTRUCTIONS:

- Complete this form for **each service area** served by the program.*
- This form **must** be signed by an employee who is in position to make hiring decisions on behalf of the employer.

Name of Institution Florida Vocational Institute		
Address 7757 W Flagler Street Suite 220		City/State/Zip Miami, Florida 33144
Name of Program Patient Care Technician		
Mode(s) of Delivery of Program (check ALL that apply):		
<input checked="checked" type="checkbox"/> 100% Traditional	<input type="checkbox"/> Hybrid	<input type="checkbox"/> Distance Education

The length of this program is (indicate the number of hours in all boxes that apply):

<input type="text" value="600"/> Clock Hours	<input type="text"/> Semester Credit Hours	<input type="text"/> Quarter Credit Hours
--	--	---

The amount of tuition and fees charged for the total program is: \$

9,849.00

EMPLOYERS' VERIFICATION STATEMENT:

I have reviewed the (name of program): Patient Care Technician and Nursing Assistant/Home Health Aide

program and recommended requirements for admissions, program content, program length, program objectives, competency tests, instructional materials, equipment, method of evaluation, the skills and/or proficiency required for completion, and appropriateness of the instructional delivery method(s) for the program which include (check **ALL** that apply):

<input checked="checked" type="checkbox"/> 100% Traditional	<input type="checkbox"/> Hybrid	<input type="checkbox"/> Distance Education
---	---------------------------------	---

EMPLOYER

Name: <u>Harlen Gonzales</u>	Title: <u>RN.</u>
Company Name: <u>Baptist Hospital.</u>	Phone Number: <u>786-314-4579</u>
Address: <u>8100 N. Kendall Dr.</u>	City/State/Zip: <u>Miami FL 33176</u>
Verifiable range of remuneration (based on year-round, full-time employment) that can reasonably be expected by completers who enter this field upon completion of the program is from \$ <u>23,000</u> annually to \$ <u>25,000</u> annually.	
Signature: <u>[Signature]</u>	Date: <u>2/11/16</u>