Clemson University - School of Nursing

MS-DNP Verification of Master's Educational Program Hours

It is best to submit this form with your online Graduate School application. *Or you may email to achiles@clemson.edu*

Applicant Information: (Complete this section and forward to the Program Director or Dean of the advanced practice program you completed)

Student Name (Last, First, MI): ____

Other Names: ____

Name of Institution from which Degree was Awarded:____

In signing this form, I give permission for the Institution named above to provide the requestedinformation.

Applicant Signature:____**Date:** ____________________

School/College of Nursing Official (Program Director or Dean): The above-named applicant hasapplied for admission to the *Clemson University School of Nursing Doctor of Nursing Practice* program. Please verify the total number of supervised/precepted practice hours (both direct and indirect practice experiences) completed by the applicant while enrolled in your MS/MSN or Post-Master's NP program

University/College/Program Name: ____

Mailing Address: ____

Type of Degree (e.g., MS, MSN, Post-Master's):____

Total Number of Preceptor-Supervised Practice Hours Completed: ______________________________

Concentration Area (e.g., Family, Adult/Gerontology, Pediatrics, Women's Health, Education, Administration):

____

Month/Day/Year of Graduation: ____

Nursing Official and Title (Please print clearly): ____

Email address:____**Phone Number:** ____________________

Signature of School/College Official:____**Date:** ____________________