

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 requested information.

Applicant Signature: _____ **Date:** _____

School/College of Nursing Official (Program Director or Dean): The above-named applicant has applied 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:** _____