Clemson University - School of Nursing
Doctor of Nursing Practice Clinical Hours Verification

Please return by submitting into your application or by email to achiles@clemson.edu no later than August 1st.

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 hands-on, supervised/precepted clinical hours and total program hours completed by the applicant while enrolled in your MS/MSN or postmaster's NP program.

University/College/Program Name: _____

School Mailing Address: _____

Type of Degree (e.g. MS, MSN, Postmasters):_____

Total Number of Hands-On Hours Completed: _____

Total Number of Hours Completed: _____

Concentration Area (e.g. Family, Adult/Gerontology, Pediatrics, Womens' Health): _____

Month/Day/Year of Graduation: _____

Nursing Official and Title (Please print clearly): _____

Email address: _____ **Phone Number:** _____

Signature of School/College Official: _____ **Date:** _____