Verification of Post-Baccalaureate Clinical and Practice Hours

DNP Applicant: Please forward this form to the program director of the advanced practice program that you completed and request that this form be duplicated on school letterhead. Ask the program director to complete the form and include his or her signature. This document is needed prior to an offer of admission to the DNP program. The completed form may be submitted to the DNP Program Manager by fax at 205-934-3115 or by email to jlavier@uab.edu. Please title this document Verification of Post-Baccalaureate Clinical and Practice Hours.

Name _____________________________________ Social Security Number __________________
  Last   First   Middle (Preferred)
  or Student ID __________________________

1. Name of University ______________________________________________________________
   Program Name ____________________________________________________________________
   University Address _______________________________________________________________
   Street/Box Number     City     State     Zip
   University Telephone ______________________________________________________________

2. Type of Degree or Certificate Received
   _____ Master of Science in Nursing Program
   _____ Post-Master’s Certificate Program

3. Area of Concentration _____________________________________________________________

4. Date of Program Completion _______________________________________________________

5. Total Number of Clinical Practice Hours in Program _________________________________
   Clock Hours

6. Your signature on this form attests that the above named individual has completed the program indicated on this document.

Program Director (Print Name) _____________________________________________________

Program Director Signature ____________________________________________ Date __________

This form may be duplicated as needed.