Verification of Post-Baccalaureate Supervised Clinical and Practicum Hours

Please complete and sign Section A. Forward this form to the program director of the school where you completed your MSN or master's degree. Ask the program director to complete and sign Section B. Return the completed form via email to *DNP@tesu.edu*. For questions about this form, call (609) 633-6460.

Section A

Student's Name (print): I give permission for the information on this form to be released to Thomas Edison State University.

Student's Signature: _____ Date: _____

Section B (to be completed by program director)

1. Name of College or University: _____
2. Address of College or University: _____
3. Phone Number of Program Director: _____
4. Degree and/or Post-Master's Certificate Earned: _____
5. Area of Concentration or Specialty: _____
6. Supervised Post-Baccalaureate Clinical or Practicum Hours Completed

   # hours completed on educational process, curriculum issues, or educating nursing students: _____

   # hours completed with a focus on direct patient care: _____

   # hours completed with a focus on administrative or system-level issues that impact patient or population outcomes: _____

   # hours completed in other activities: _____

   Please describe activities:_____

   _____

   _____

Total number of supervised post-baccalaureate clinical or Practicum hours completed: _____

7. Date of Program Completion: _____
8. Our signature on this form attests that the above named individual has completed the program and number of clinical or Practicum hours indicated on this form.
9. Program Director's Name (Please Print):_____
10. Program Director's Signature: _____