UNIVERSITY OF SOUTHERN MAINE
SCHOOL OF NURSING
DOCTOR OF NURSING PRACTICE (DNP)

Verification of Post-Baccalaureate Clinical and Practice Hours

DNP Applicant: Please allow sufficient time for the program director to complete and return this form to you for inclusion with your application. The program director should complete items 1-6 and return the form to the applicant.

Please print clearly or type

Name _____
Last *First* *Middle* *Preferred*

Social Security Number or Student ID _____

1. Name of University _____

   Program Name _____

   University Mailing Address _____

   _____

   University Telephone _____

2. Type of Degree 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 verifies that the above named individual has completed the program indicated on this document.

Program Director (Print Name) _____

Program Director Signature _____Date _____

University of Southern Maine
School of Nursing
Updated: 10.2010