Doctor of Nursing Practice Program
Georgia College and State University
School of Nursing
Verification of Graduate Clinical and Practice Hours

Instructions:
The DNP applicant should forward this form to the program director for completion. Once the form is completed, it should be returned to the applicant, for submission with other supplemental materials.

Student Name (Print or type):____
First Middle/Maiden Last
Student School ID Number:____

<u>The information below *must be completed by the program director*</u>

1. **Name of University:**____
   Program Name:____
   University Address:____
   University Telephone:____

2. **Type of Degree Received:**
   ____Masters 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 the 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:____