

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
College of Nursing Graduate Program

Name: _____ Completed by: _____

Specialty: _____

Date: _____ Academic Advisor: _____

PROGRAM OF STUDY

FALL			SPRING			SS		
Semester Year	Campus		Semester Year	Campus		Semester Year	Campus	
Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.
Total:			Total:			Total:		

FALL			SPRING			SS		
Semester Year	Campus		Semester Year	Campus		Semester Year	Campus	
Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.
Total:			Total:			Total:		

FALL			SPRING			SS		
Semester Year	Campus		Semester Year	Campus		Semester Year	Campus	
Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.
Total:			Total:			Total:		

FALL			SPRING			SS		
Semester Year	Campus		Semester Year	Campus		Semester Year	Campus	
Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.	Course No.	Name	Cr. Hrs.
Total:			Total:			Total:		