

**University of Arkansas for Medical Sciences  
College of Nursing**

**Verification of Master's Clinical and Practice Hours  
Doctor of Nursing Practice Program**

The DNP applicant should complete the top and send this form to the program director for completion.

**Student's Name (Print or type):** \_\_\_\_\_  
(Last) (First) Middle (Maiden/Other)

**Student's SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**The information below must be completed by the program director**

Name of Institution: \_\_\_\_\_  
Program Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
University Telephone: \_\_\_\_\_

Type of Degree Received:  Masters of Science in Nursing Program  
 Post Master's Certificate Program

Specialty: \_\_\_\_\_

Date of Program Completion: \_\_\_\_\_

Total number of clinical practice hours in the program (clock hours): \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Please print name): \_\_\_\_\_

E-mail address: \_\_\_\_\_

**When form is completed, please send it to:**

UAMS-College of Nursing  
4301 W Markham #529  
Little Rock, AR 72205  
501-686-8351 (phone)  
501-686-7591 (fax)  
conadmissions@uams.edu