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