Capstone College of Nursing
The University of Alabama

Verification of Post-Baccalaureate Clinical Hours

DNP Applicant: Please allow sufficient time for the program director of your MSN or Post-Master's program 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 to include with an application.

(Please print legible or type)
Name _____ Social Security Number_____
Last, First Middle Preferred or Student ID_____

1. Name of University _____

   Program Name _____

   University Address_____
   Street/Box Number City State Zip

   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 attests that the above named individual has completed the program indicated on this document.

Program Director (Print Name) _____

Program Director Signature_____ Date_____

This form may be duplicated as needed.